No. 83 56

In the Supreme Court of the United States

OCTOBER TERM, 1983

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES,
PETITIONER

v.

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTION PRESENTED

Whether the Secretary of Health and Human Services may be estopped from recovering excess payments made to a provider of health care services under the Medicare program on the ground that a fiscal intermediary previously had advised the provider that the payments were allowable.

PARTIES TO THE PROCEEDINGS

In addition to the parties named in the caption, Ada Werner, Frank E. Werner, and Shirley Sorger were appellants and the Travelers Insurance Companies was an appellee in the court of appeals.

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The Solicitor General, on behalf of the Secretary of Health and Human Services, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App. A, *infra*, 1a-33a) is reported at 698 F.2d 615. The opinions of the district court (App. C, *infra*, 36a-48a) and the Provider Reimbursement Review Board (App. D, *infra*, 49a-54a) are not reported.

JURISDICTION

The judgment of the court of appeals (App. E, *infra*, 55a-56a) was entered on January 19, 1983. A petition for rehearing was denied on February 14, 1983 (App. B, *infra*, 34a-35a). On May 6, 1983, Justice Brennan extended the time for filing a petition for a writ of certiorari to and including July 14, 1983. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTE AND REGULATIONS INVOLVED

Section 1815(a) of the Social Security Act, 42 U.S.C. 1395g(a), provides:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

Section 1861(v)(1)(A) of the Social Security Act, 42 U.S.C. 1395x(v)(1)(A), provides in part that the Secretary's regulations governing the determination of the reasonable cost of services shall

> provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

42 C.F.R. 405.423 provides in part:

> (a) *Principle.* Unrestricted grants, gifts, and income from endowments should not be deducted from operating costs in computing reimbursable cost. Grants, gifts, or endowment income designated by a donor for paying specific operating costs should be deducted from the particular operating cost or group of costs.
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> (c) *Application.*
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> * * * * *
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> (2) Donor-restricted funds which are designated for paying certain hospital operating expenses

should apply and serve to reduce these costs or group of costs and benefit all patients who use services covered by the donation. If such costs are not reduced, the provider would secure reimbursement for the same expense twice; it would be reimbursed through the donor-restricted contributions as well as from patients and third-party payers including the title XVIII health insurance program.

* * * * *

42 C.F.R. 405.1885 provides in part:

(a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision, or where there has been no such decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

(b) A determination or a hearing decision rendered by the intermediary shall be reopened and revised by the intermediary, if, within the aforementioned 3-year period, the Health Care Financing Administration notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the intermediary.

STATEMENT

1. This case raises the question whether the Secretary of Health and Human Services may be estopped from recovering excess payments made to a provider of health care

services under the Medicare program on the ground that a fiscal intermediary had previously advised the provider that the payments were allowable. Title XVIII of the Social Security Act, 42 U.S.C. (& Supp. V) 1395 *et seq.*, establishes Medicare, a two-part program of federal assistance for the medical care of the aged and disabled. Part A of the program provides "hospital insurance" benefits (inpatient hospital care and post-hospital extended or home health care) and is financed by Social Security payroll contributions. 42 U.S.C. (& Supp. V) 1395c-1395i-2. Part B of the program provides "medical insurance" benefits for physician services and outpatient services and supplies and is financed by the premium payments of enrollees together with contributions from funds appropriated by Congress. 42 U.S.C. (& Supp. V) 1395j-1395w. Both parts of the program are administered by the Health Care Financing Administration ("HCFA"), a part of the Department of Health and Human Services ("HHS"). This case involves payments made under Part A of the program.

Health care providers of Part A services are generally hospitals, skilled nursing facilities, and home health agencies. Instead of reimbursing Part A Medicare beneficiaries directly, the Secretary of Health and Human Services pays the provider for the health care services it has rendered to beneficiaries. The Medicare statute provides for reimbursement only for the "reasonable cost of any services," which is defined as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. 1395x(v)(1)(A). See also 42 U.S.C. (Supp. V) 1395f(b). Congress has given the Secretary express statutory authority to establish the methods for determining "reasonable costs" for services. See 42 U.S.C. 1395x(v)(1)(A).[1] The Secretary has exercised this authority by promulgating regulations, 42 C.F.R. 405 *et seq.*, and a series of Health Insurance Manuals.

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[1] In addition, Congress has delegated to the Secretary general authority to prescribe regulations necessary to carry out the administration of the Medicare program under Section 1871 of the Social Security Act, 42 U.S.C. 1395hh.

A provider receives interim payments at least monthly for its estimated reasonable costs incurred in furnishing services to Medicare beneficiaries. 42 U.S.C. (& Supp. V) 1395f, 1395g. A provider's annual cost report is audited later to determine the actual costs incurred. See 42 C.F.R. 405.454, 405.1803. Congress was aware that under this type of reimbursement system it was likely that health care providers would receive overpayments or underpayments at various times. Therefore, it instructed the Secretary to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. 1395x(v)(1)(A)(ii). The Secretary responded to this congressional directive by promulgating 42 C.F.R. 405.1885, which provides for the reopening, within a three-year period, of any reimbursement determination made by an intermediary, a hearing officer, the Provider Reimbursement Review Board, ("PRRB"), or the Secretary herself. The statute also provides that interim payments to providers shall include "necessary adjustments on account of previously made overpayments or underpayments." 42 U.S.C. 1395g(a). See also 42 C.F.R. 405.454(f), 405.1803(b). In addition, determinations of a fiscal intermediary respecting the total amount of reimbursement payable to a provider for a given cost year are subject to administrative and judicial review. 42 U.S.C. (& Supp. V) 1395*oo*; 42 C.F.R. 405.1801 *et seq.*

At the provider's option, a nongovernmental organization (frequently a private insurance company) may act as "fiscal intermediary." 42 U.S.C. (& Supp. V) 1395h. The intermediary is nominated by the provider, but it enters into agreements with the Secretary and acts on behalf of the Secretary in certain respects. See 42 C.F.R. 421.5(b). The intermediary audits the provider's cost reports and makes payments to the provider for the reasonable cost of services supplied to Medicare beneficiaries. Under the statute the intermediary may also "serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communi-

cation from providers to the Secretary." 42 U.S.C. (Supp. V) 1395h(a)(2)(A).

2. Respondent Community Health Services of Crawford County, Inc. ("CHS"), is a provider of health care services and has participated in the Medicare program since 1966. CHS chose to have its Medicare payments made through a fiscal intermediary, Travelers Insurance Companies ("Travelers"). In 1975 CHS began to receive grant funds under the Comprehensive Employment and Training Act of 1973 ("CETA"), 29 U.S.C. (& Supp. V) 801 *et seq.*, a federal program designed to provide job training and employment opportunities. CHS employed CETA workers, whose salaries and fringe benefits were required to be paid with the federal CETA funds CHS received. CHS included in its Medicare cost reports for 1975, 1976 and 1977 the amount of salaries and fringe benefits paid to CETA workers, but did not offset against these costs the federal CETA funds it had received to cover them. App. A, *infra*, 3a-5a. Accordingly, when it received Medicare reimbursement on the basis of its cost reports, CHS in effect received a second, duplicate payment for the expenses of the CETA workers.

One of the Secretary's regulations relating to determination of reasonable costs, 42 C.F.R. 405.423(a), provides that grants received by a provider for the purpose of paying specific operating costs "should be deducted from the particular operating cost or group of costs" in computing reimbursable costs. That regulation is in furtherance of the principle that a provider may not be reimbursed twice for the same expense.[2] Section 612 of the Medicare Provider Reimbursement Manual carves out a limited exception to this offset rule; when an earmarked grant constitutes "seed money," the funds need not be offset against the costs for which they are designated. Seed money grants are defined as "[g]rants designated for the development of new health care agencies or for expansion of services of established agencies * * *." *Medicare Pro-*

[2] See 42 C.F.R. 405.423(c)(2) ("[i]f such costs are not reduced, the provider would secure reimbursement for the same expense twice; it would be reimbursed through the donor-restricted contributions as well as from patients and third-party payers including [Medicare]").

vider Reimbursement Manual, HIM-15, Pt. I, § 612.2, reproduced in 1 Medicare & Medicaid Guide (CCH) ¶ 5461 (Aug. 1968).

CHS filed its cost reports after consulting with Travelers, its fiscal intermediary. In response to CHS's inquiries, Travelers' Medicare Manager, Michael Reeves, orally advised CHS on several occasions from 1975 to August 1977 that CETA funds constitute "seed money" and therefore need not be deducted from reimbursable costs. Neither Reeves nor CHS consulted HCFA about the matter during this period. App. A, *infra*, 5a. In August 1977 Travelers inquired of HCFA in writing whether CETA funds constitute seed money and thus are exempt from the general principle of offset. HCFA advised Travelers in writing that CETA funds do not constitute seed money and must be offset against the costs of CETA employees. Reeves informed CHS of HCFA's advice by letter (October 7, 1977) and in person (November 9, 1977). *Id.* at 6a. Nevertheless, CHS did not offset the CETA funds in its cost report for the year 1977, which it submitted in February 1978. Travelers adjusted the 1977 cost report to reflect the receipt of CETA funds. App. D, *infra*, 50a.

In June 1978 Travelers sent CHS written notice that its failure to offset CETA funds had resulted in overpayments for 1975, 1976 and 1977 amounting to $71,480 (C.A. App. 25a-28a). The notice informed CHS of the possibility of establishing an extended repayment schedule if CHS could provide adequate documentation supporting its financial condition and a proposed schedule of payments (C.A. App. 25a, 33a). Following receipt of this notice, CHS and three individual recipients of home health care services provided by CHS (respondents Ada Werner, Frank E. Werner, and Shirley Sorger) filed a civil action in the United States District Court for the Western District of Pennsylvania, seeking to enjoin the Secretary from recouping the overpayments. On August 10, 1978, the district court granted a temporary restraining order requiring the Secretary to refrain from recoupment of the overpayments. App.

A, *infra*, 7a. CHS then pursued its administrative remedies before the PRRB.[3]

On March 12, 1980, following an evidentiary hearing, the PRRB ruled that CETA grants do not constitute seed money and must be offset against costs, as required by 42 C.F.R. 405.423 (App. D, *infra*, 49a-54a). While acknowledging CHS's claim that its failure to offset CETA funds was due to the advice it received from the intermediary, the PRRB declined to conclude that the failure to offset was justified. It pointed out that "advice by the Intermediary cannot be a substitute for the opinion of the Secretary" (*id.* at 54a).[4]

CHS sought review of the PRRB decision in district court, contending, *inter alia*, that CETA funds constitute seed money, that the Secretary was estopped from recouping the overpayments, that the Secretary should have waived recovery, and that Travelers was independently liable for the overpayments. The district court consolidated CHS's appeal from the PRRB decision with the suit it had filed in 1978. The court rejected each of CHS's contentions and granted the Secretary's motion for summary judgment (App. C, *infra*, 36a-48a). The court found that the language of 42 C.F.R. 405.423(a) supports the Secretary's ruling that CETA grants are not seed money. It concluded that CETA funds plainly are not "designated for the development of new health care agencies" and that "no tortured construction" could bring CETA grants within the seed money exception (App. C, *infra*, 40a).

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[3] Pursuant to a stipulation between the parties, the Secretary has refrained from recouping the overpayments during the pendency of the administrative proceeding and judicial review and has refunded the amounts previously recouped (C.A. App. 107a-108a).

[4] However, the PRRB reversed the proposed adjustments to the 1975 and 1976 cost reports, because the provider had not been given proper notice of reopening (App. A, *infra*, 8a; App. D, *infra*, 53a-54a). The notice for the year 1976 was reissued in compliance with the applicable regulations, but the notice for the year 1975 could not be reissued, since the three-year reopening period provided by the regulations had passed. Accordingly, the total amount of adjustment was reduced to $63,839, representing the overpayments for 1976 and 1977. App. A, *infra*, 8a. The PRRB decision was the final decision of the Secretary in this case.

The district court also rejected CHS's estoppel argument. The court suggested that estoppel may lie against the government "in certain limited circumstances" (App. C, *infra*, 41a). However, it ruled that the existence of the Secretary's regulation permitting the reopening of reimbursement determinations within a three-year period and the obvious fact that CHS was being reimbursed twice for the same expense defeated its estoppel contention. The court stated (*id.* at 42a):

> The Medicare regulations allow the intermediary to reopen the cost reports up to three years after they have been approved. Thus, CHS relied at its own risk in accepting the intermediary's advice since plaintiff was on notice that all such reports were subject to review. Moreover, the fact that CHS was being reimbursed twice for the same expense should have been a red flag that its windfall was not supportable under the Act.

Finally, the district court rejected CHS's claims that a provision of the Medicare statute entitled it to waiver of the overpayments and that Travelers was independently liable for the failure to render accurate advice concerning the treatment of CETA funds. The court held that mistakes of judgment do not constitute activity outside the intermediary's scope of authority when such mistakes in the treatment of cost items were anticipated by the reopening provision of 42 C.F.R. 405.1885. The court found "no evidence of willful or wanton misconduct" by Reeves (App. C, *infra*, 46a).

3. A divided panel of the court of appeals reversed (App. A, *infra*, 1a-33a). While it recognized the traditional reluctance of courts to apply estoppel against the government, the court of appeals nonetheless held that the Secretary should be estopped from recovering the overpayments from CHS.

The court of appeals viewed this Court's decisions as supporting the principle that "estoppel may be properly applied against the government under certain circumstances" and as giving "tacit recognition" to the use of estoppel against the government upon a finding of "affirmative misconduct" (App. A, *infra*, 10a). The court concluded that the behavior of the intermediary in this case constituted "af-

firmative misconduct" (*id.* at 3a, 15a). It reasoned that the Medicare statute and Travelers' agreement with the Secretary created a "legally binding procedure," under which Travelers was obliged to communicate CHS's inquiry regarding CETA funds to HCFA in a timely manner (*id.* at 15a-16a), and that Travelers had "knowingly violated statutory and procedural guidelines" in failing to follow that procedure (*id.* at 15a). The court concluded that if Travelers had initially consulted HCFA, "CHS would not have been misled" (*id.* at 15a-16a).

The court of appeals distinguished this Court's estoppel decisions on a variety of grounds (App. A, *infra*, 16a-21a). It distinguished *FCIC* v. *Merrill*, 332 U.S. 380 (1947), on the ground that there was "no source to which CHS could have gone to ascertain whether the government agent's advice was wrong" (App. A, *infra*, 17a). Despite the existence of 42 C.F.R. 405.423, the Secretary's regulation requiring the offset of earmarked grants against costs, the court concluded that there was no applicable regulation in force at the time CHS consulted the intermediary (App. A, *infra*, 17a). The court did not find relevant either the requirement of 42 U.S.C. (& Supp. V) 1395g that there be retroactive adjustments to account for overpayments or underpayments to providers, or 42 C.F.R. 405.1885, the Secretary's regulation authorizing reopening of intermediary reimbursement determinations within three years. Instead, it emphasized "the injustice to CHS and the people it serves if it is required to refund the alleged overpayments" (App. A, *infra*, 21a), remarking that the excess Medicare funds had been used "to meet serious human needs" (*ibid.*).

Judge Meanor dissented (App. A, *infra*, 23a-33a). In his view, the government cannot be estopped when the result would be to "render to the opponent a benefit to which he was never substantively entitled" (*id.* at 24a). Judge Meanor found this Court's decision in *FCIC* v. *Merrill*, *supra*, to be controlling (App. A, *infra*, 26a). He concluded that estopping the government in a case like this one "amounts to no more than a court authorized raid on the public treasury" (*id.* at 32a).

REASONS FOR GRANTING THE PETITION

Despite this Court's recent decisions repeating the longstanding principle that estoppel against the government is rarely, if ever, appropriate, the lower courts continue to disregard that principle. Thus, once again, we seek review of a decision that raises important questions concerning whether and in what circumstances the government may be equitably estopped from enforcing statutory restrictions on payments from the federal treasury. The court of appeals has held that, because a fiscal intermediary erroneously advised a health care provider that certain costs were reimbursable under the Medicare Act, the Secretary is barred from recovering overpayments made to the provider. The court below reached this result despite the fact that under the statute and regulations the provider was not entitled to receive the funds and despite the fact that Congress has expressly directed the Secretary to recover such overpayments.

The court of appeals' decision cannot be reconciled with the unbroken line of this Court's cases establishing that the government may not be estopped, at least in the absence of serious affirmative misconduct. See, *e.g.*, *INS* v. *Miranda*, No. 82-29 (Nov. 8, 1982); *Schweiker* v. *Hansen*, 450 U.S. 785 (1981); *INS* v. *Hibi*, 414 U.S. 5, 8 (1973); *Montana* v. *Kennedy*, 366 U.S. 308, 314-315 (1961); *FCIC* v. *Merrill*, 332 U.S. 380 (1947). In particular, the decision conflicts with this Court's repeated instruction to the lower courts "'to observe the conditions defined by Congress for charging the public treasury.'" *Schweiker* v. *Hansen*, *supra*, 450 U.S. at 788, quoting *FCIC* v. *Merrill*, *supra*, 332 U.S. at 385. The lower courts continue to disregard that instruction and to express confusion over the proper application of this Court's estoppel rulings.[5] For that rea-

[5] See, *e.g.*, *Home Savings & Loan Ass'n* v. *Nimmo*, 695 F.2d 1251 (10th Cir. 1982); *Portmann* v. *United States*, 674 F.2d 1155 (7th Cir. 1982); *Meister Bros.* v. *Macy*, 674 F.2d 1174 (7th Cir. 1982); *McDonald* v. *Schweiker*, 537 F. Supp. 47 (N.D. Ind. 1981); *Armstrong* v. *United States*, 516 F. Supp. 1252 (D.Colo. 1981). Despite this Court's firm stand against estoppel of the government, the court of appeals here characterized the issue as "far from settled" (App. A, *infra*,

son, and because the decision of the court of appeals threatens the sound administration of the Medicare program, as well as a wide range of other federal programs, by preventing recovery of substantial sums of money owed to the government, review by this Court is warranted.

1. a. Since the earliest days of the Nation, this Court has repeatedly and consistently held that the government may not be equitably estopped from enforcing the laws, even though private parties may, as a result, suffer hardship in particular cases. See, *e.g.*, *Lee* v. *Munroe & Thornton*, 11 U.S. (7 Cranch) 366, 369-370 (1813); *Hart* v. *United States*, 95 U.S. 316, 318-319 (1877); *Pine River Logging Co.* v. *United States*, 186 U.S. 279, 291 (1902); *Utah Power & Light Co.* v. *United States*, 243 U.S. 389, 408-409 (1917); *Sutton* v. *United States*, 256 U.S. 575, 579 (1921); *Utah* v. *United States*, 284 U.S. 534, 545-546 (1932); *Wilber National Bank* v. *United States*, 294 U.S. 120, 123-124 (1935); *United States* v. *Stewart*, 311 U.S. 60, 70 (1940); *FCIC* v. *Merrill*, *supra*, 332 U.S. at 384; *Automobile Club* v. *Commissioner*, 353 U.S. 180, 183 (1957); *Montana* v. *Kennedy*, *supra*, 366 U.S. at 314-315; *INS* v. *Hibi*, 414 U.S. 5, 8 (1973); *Schweiker* v. *Hansen*, *supra*; *INS* v. *Miranda*, *supra*. Indeed, we know of no decision of this Court holding that estoppel lies against the government in any circumstance.[6]

This rule is founded on the doctrines of sovereign immunity and separation of powers. See, *e.g.*, *United States* v. *Testan*, 424 U.S. 392, 399 (1976); *Dixon* v. *United States*, 381 U.S. 68, 73 (1965); *Snyder* v. *Buck*, 340 U.S. 15, 19 (1950); *United States* v. *San Francisco*, 310 U.S. 16, 29-32 (1940). The actions of government employees cannot alter the terms and conditions established by Congress for the payment of money from the federal treasury. By the same

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9a). See also *Schweiker* v. *Hansen*, *supra*, 450 U.S. at 792 (Marshall, J., dissenting).

[6] In several cases the Court has declined to determine whether the government would be estopped in a case involving serious affirmative misconduct. See, *e.g.*, *INS* v. *Miranda*, *supra*, slip op. 3; *Schweiker* v. *Hansen*, *supra*, 450 U.S. at 788. However, the Court has never identified a case in which the facts established such misconduct.

token, if the judiciary were free to impose otherwise unauthorized liability on the government based simply on its notions of equity, the sovereign would be virtually powerless to control and protect the public fisc.

Despite this Court's repeated directives to the lower courts to observe the conditions Congress has set for charging the public treasury, the court of appeals held that the Secretary may not recover overpayments that respondent CHS was never entitled to receive under the Medicare statute. Congress has provided expressly that reimbursement of Medicare providers must be limited to the "reasonable cost" of the services they provide, as that term is defined by the Secretary through promulgation of regulations. 42 U.S.C. 1395x(v)(1)(A). As part of her regulations defining "reasonable cost," the Secretary has required that grants earmarked for specific operating costs be offset against those costs for purposes of Medicare provider claims, 42 C.F.R. 405.423(a), in order to avoid double reimbursement for the same expenses.[7]

Moreover, Congress has anticipated reimbursement errors and has directed the Secretary to make necessary ad-

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[7] The Secretary has created a limited exception to this offset rule in the case of "seed money" grants, which are grants made for the purpose of establishing or expanding health care agencies. The *Medicare Provider Reimbursement Manual*, HIM-15, Pt. I, § 612.2, reproduced in 1 Medicare & Medicaid Guide (CCH) ¶ 5461 (Aug. 1968), provides:

> Grants designated for the development of new health care agencies or for expansion of services of established agencies are generally referred to as "seed money" grants. "Seed money" grants are not deducted from costs in computing allowable costs. These grants are usually made to cover specific operating costs or group of costs for services for a stated period of time. During this time, the provider will develop sufficient patient caseloads to enable continued self-sustaining operation with funds received from Medicare reimbursement as well as from funds received from other patients or other third-party payers.

As the Manual indicates, "seed money" grants generally are one-time grants. Examples include grants under the Health Underserved Rural Areas program, 42 U.S.C. (& Supp. V) 1310, and grants under the Rural Health Initiative Program, 42 U.S.C. (& Supp. V) 201 *et seq.* Part A Intermediary Letter, No. 79-47, reproduced in [1979-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 30,110 (Dec. 1979).

justments in reimbursement "on account of previously made overpayments or underpayments," 42 U.S.C. 1395g(a), and to "provide for the making of suitable retroactive corrective adjustments" in the case of underpayment or overpayment to a provider. 42 U.S.C. 1395x(v)(1)(A).

Here, CHS submitted cost reports in which it claimed reimbursement for salaries and fringe benefits of CETA employees, but failed to offset the federal CETA funds it had received to cover those very expenses. Because CETA funds are not within the seed money exception to the Secretary's offset rule (see note 7, *supra*), CHS's cost reports were overstated. The reimbursement based on those cost reports thus included funds to which CHS was not entitled under the Medicare statute—funds to cover costs that in fact already had been reimbursed by grants CHS received under a different federal program. The Secretary, pursuant to Congress's mandate and applicable regulations, reopened CHS's cost reports, adjusted them to account for the failure to offset, and attempted to recover the overpayments previously made to CHS. The court of appeals' decision to estop the Secretary from recovering the overpayments frustrates both the substantive limitations Congress placed on entitlement to Medicare reimbursement and the scheme it established for recovery of overpayments from providers.

b. The court of appeals concluded that the Secretary should be estopped from recovering overpayments from CHS because Travelers, the fiscal intermediary, advised CHS on several occasions that it was not necessary to offset CETA funds. But this Court's decisions plainly establish that neither the intermediary's conduct nor CHS's reliance on the intermediary's advice warrants estoppel.

It is quite clear that the conduct at issue here does not justify estopping the government from enforcing the Medicare statute. The court of appeals characterized Travelers as having engaged in "affirmative misconduct" because it advised CHS that the amounts claimed were allowable and because it failed to consult HCFA about the proper treatment of CETA funds. Even if there is an exception to the general rule against estopping the government in cases of serious affirmative misconduct, Travelers' conduct does not

meet that test. The district court found (App. C, *infra*, 46a) that the actions of the intermediary did not amount to "willful or wanton misconduct," but at most constituted a mistake in judgment. Indeed, the conduct in this case is essentially indistinguishable from conduct involved in prior decisions of this Court. For example, in *Schweiker* v. *Hansen*, *supra*, a Social Security claims representative incorrectly advised the claimant that she did not qualify for insurance benefits under 42 U.S.C. (Supp. V) 402(g), and failed to advise her to file a written application for benefits, contrary to instructions in the Social Security Claims Manual. In *FCIC* v. *Merrill*, *supra*, a government agent incorrectly informed a wheat farmer that his crop would be insured, although applicable regulations clearly provided that the crop was not insurable. In both of these cases the Court concluded that the government employee's erroneous advice and failure to take steps to discover the correct information fell "far short of conduct which would raise a serious question whether [the government] is estopped from insisting on compliance with [a] valid regulation." *Schweiker* v. *Hansen*, *supra*, 450 U.S. at 790.[8] Thus, the absence of any affirmative misconduct in this case alone is sufficient to require reversal of the decision below.

Estoppel is also improper for the independent reason that there is a complete absence of any reasonable reliance by CHS on the advice rendered by the intermediary. The Medicare program rests on a system of interim payments and subsequent adjustments for overpayments or underpayments. CHS was on notice that the statute and regulations provide for retroactive adjustments to account

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[8] The court of appeals placed considerable weight on its conclusion that the intermediary failed to carry out what the court referred to as a "legally binding procedure"—consultation with HCFA on matters not settled by statute or regulation (App. A, *infra*, 15a-16a). The Medicare statute, 42 U.S.C. (Supp. V) 1395h(a), states that agreements between the Secretary and intermediaries may provide that the intermediary will serve as a channel of communication between providers and the Secretary. However, there is no indication that Congress intended to impose a duty that would be enforceable by providers in individual instances or that could operate to estop the Secretary from recovering overpayments made to providers.

for overpayments or underpayments; in fact, 42 C.F.R. 405.1885 expressly provides that any intermediary determination may be reopened at any time within three years of the determination if it is found to be inconsistent with the statute, regulations, or HCFA general instructions. The court of appeals virtually ignored these important provisions. But as the district court noted (App. C, *infra*, 42a), the provisions meant that CHS "relied at its own risk in accepting the intermediary's advice." In view of the provisions for reopening of intermediary determinations and retroactive adjustments, it is difficult to understand how any Medicare provider could contend that it reasonably relied on an intermediary's advice as a conclusive construction of the Act.

Moreover, the advice CHS received was oral, not written, and was given informally by an individual who clearly was not in a position to make definitive interpretations of the statute and the Secretary's regulations. See *Schweiker* v. *Hansen*, *supra*, 450 U.S. at 788-789 & n.4. On their face, the regulations require offset of earmarked grants, with no mention of an exception for CETA grants.[9] CHS presumably was aware of these regulations; thus, its reliance on the contrary advice of the intermediary cannot be viewed as reasonable. In addition, as the district court found (App. C, *infra*, 42a), the fact that CHS was receiving double reimbursement for the expenses of hiring CETA employees should have been a "red flag" to CHS.[10]

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[9] CHS argued below that CETA funds should be considered to be seed money, because the contract under which it received the CETA funds stated that they would be used to supplement, rather than supplant, the level of funds otherwise available. See App. D, *infra*, 51a. However, the statutory condition referred to, Section 703(11) of CETA, makes clear that the reference is to supplementation of *non-federal* sources of funds. See 29 U.S.C. 983(11) (formerly Title VI, Section 603(11), of Pub. L. No. 93-203, 87 Stat. 878). Moreover, the definition of seed money found in the *Medicare Provider Reimbursement Manual* (see note 7, *supra*) refers only to grants designated for the development or expansion of health care agencies. CETA funds are not directed to health care agencies, but are intended to increase employment opportunities generally. See 29 U.S.C. (Supp. V) 801.

[10] The mere fact that CHS claims to have consulted Travelers on a number of occasions about the treatment of CETA funds suggests that it had continuing doubts about the advice it was receiving.

Absent reasonable reliance, equitable estoppel is inappropriate in any case; a fortiori, the government may not be estopped in a case like this one, in which the provider's reliance on the intermediary's advice plainly was unreasonable. The court of appeals disregarded this point, focusing instead on what it characterized as the "manifest injustice" to CHS and its clients (App. A, *infra*, 21a). Even if this characterization were correct, it would make no difference to the outcome of this case. This Court has held repeatedly that even substantial detrimental reliance on a government official's misinformation does not give rise to an estoppel. See, *e.g.*, *Montana* v. *Kennedy*, *supra*, 366 U.S. at 314-315 (detrimental reliance on misinformation resulting in loss of citizenship); *Dixon* v. *United States*, *supra*, 381 U.S. at 73 (detrimental reliance on erroneous tax ruling); *FCIC* v. *Merrill*, *supra* (government not estopped from denying insurance benefits although entire wheat crop was destroyed); *United States* v. *San Francisco*, *supra*, 310 U.S. at 32 (detrimental reliance on erroneous administrative rulings resulting in loss of land).

In any event, the statutorily mandated recovery of overpayments from CHS does not amount to "manifest injustice." CHS never had any substantive entitlement to the funds at issue. In fact, it was reimbursed twice for the same expense, from two different sources of federal funds. Thus, it received a windfall, which it now seeks to retain. It is hardly unjust to require CHS to return the payments to which it was never entitled in the first place.

CHS became a Medicare provider voluntarily and presumably was aware of the risks and responsibilities it was assuming, as well as the benefits involved. As noted above, the statute and regulations make clear that retroactive adjustments will be made when overpayments occur. CHS, which had been a Medicare provider for almost a decade when it began claiming the excess funds at issue here, was familiar with the system of interim payments and subsequent adjustments.[11]

[11] The court of appeals was plainly wrong in suggesting (App. A, *infra*, 5a, 13a, 18a-19a) that CHS had no choice but to seek and follow

The court of appeals found it significant that CHS had incurred obligations based on the advice it received and that repayment might require a cut in services to CHS's clients (App. A, *infra*, 2a, 19a). CHS asserted below that it had used the extra funds to render services to the public. But it would be entirely inappropriate to preclude the Secretary from carrying out Congress's directive to recover overpayments simply because the recipients of funds had spent them. See *Bell* v. *New Jersey*, No. 81-2125 (May 31, 1983), slip op. 14 n.15 ("we would find it difficult to believe that Congress meant to permit States to obtain good title to funds otherwise owing to the Federal Government by the simple expedient of spending them"). Of course, no one required or "induced" CHS to expend the excess funds it received; ultimately, it was CHS's choice to take the risk of doing so, in the knowledge that the statute requires that retroactive adjustments be made in the case of overpayments.[12]

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the advice of the intermediary, or that CHS was "induced" to claim the excess funds. CHS was not obliged to accept unquestioningly the intermediary's advice or to act on it, especially when the advice on its face appeared to conflict with written regulations and guidelines. In such a situation, in which it is clear that erroneous advice will lead to overpayments and that the statute and regulations provide for recovery of such overpayments, the provider must exercise independent judgment. Moreover, the court of appeals erred in its assumption (*id.* at 5a, 18a-19a) that CHS could not have communicated with HCFA on this matter; we are aware of no written or unwritten policy that prohibits a provider from submitting nonroutine inquiries to HCFA, and such inquiries are not uncommon.

[12] CHS claimed below that it was unable to repay the funds it had improperly received and that it would have to reduce services to its clients if it were required to repay. These arguments, however, relate to the propriety of the Secretary's recoupment methods rather than the validity of the recoupment order. See *Bell* v. *New Jersey*, *supra*, slip op. 5 n.4. Moreover, the court of appeals ignored the fact that there are ways to avoid the dire consequences predicted by CHS. When Travelers notified CHS that it was required to repay the excess funds, it advised CHS of the option of an extended repayment schedule (C.A. App. 25a-26a). CHS apparently did not pursue this possibility, which could have largely alleviated its financial concerns. See also the Federal Claims Collection Act of 1966, 31 U.S.C. 951 *et seq.* (authorizing

In sum, nothing about this case supports the court of appeals' departure from the principles firmly established in the prior decisions of this Court. The decision below contravenes the mandate of Congress that Medicare reimbursement be confined to the reasonable cost of providing services, as determined by the Secretary, and that the Secretary take action to recover overpayments made to providers. The court of appeals simply disregarded this Court's clear directive in *Schweiker* v. *Hansen*, *supra*, 450 U.S. at 790, that "a court is [not] authorized to overlook * * * any * * * valid requirement for the receipt of [government] benefits."

2. The estoppel issue presented by this case is important. Reopening of provider cost reports and retroactive adjustments for overpayments occur with some frequency in the Medicare program. HHS recovers millions of dollars in overpayments from providers each year as a result of reopenings. Virtually all of this recovery involves initial intermediary determinations later found to be erroneous, like the determination in this case. Thus, there are substantial sums at stake in the Medicare program alone.

In addition, there are many other federal programs that involve federal funding in the form of grants, benefits, loans, or guarantees; under these programs it is often the case that funds are paid out prior to any detailed agency audit of claims or expenditures. A system of interim or advance payments and subsequent recovery of erroneous overpayments is essential to the efficient operation of such programs, including many of the massive social welfare programs created by the Social Security Act. It would lead to intolerable burdens and would require the expenditure of substantial sums of public monies contrary to the dictates of Congress if recipients could retain federal funds to which they were not statutorily entitled whenever they could show that they had claimed the funds following receipt of incorrect advice from a government agent. As Judge Meanor observed (App. A, *infra*, 32a), applying estoppel in

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compromise of a claim or termination of collection action under certain conditions, including inability to pay).

such circumstances "amounts to no more than a court authorized raid on the public treasury."

As we noted above (see pages 11-12, note 5, *supra*), the decision below is not the only recent case in which the lower courts appear to have disregarded the principles set out in this Court's decisions. The willingness of the lower courts to permit estoppel against the government and to order or approve the payment of funds contrary to Congress's directives is a matter of serious concern. The court of appeals' erroneous application of estoppel against the government thus warrants review by this Court.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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JULY 1983

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 82-5098

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., A NONPROFIT CORPORATION, ADA WERNER, AN INDIVIDUAL, FRANK E. WERNER, AN INDIVIDUAL, AND SHIRLEY SORGER, AN INDIVIDUAL, PLAINTIFFS-APPELLANTS

v.

JOSEPH A. CALIFANO, JR., SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, AND THE TRAVELERS INSURANCE COMPANIES, A CORPORATION, (D.C. CIVIL NO. 78-74 ERIE) DEFENDANTS-APPELLEES

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., A NON-PROFIT CORPORATION, PLAINTIFF-APPELLANT

v.

PATRICIA ROBERTS HARRIS, SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, AND THE TRAVELERS INSURANCE COMPANIES, A CORPORATION, (D.C. CIVIL NO. 80-056 B ERIE) DEFENDANTS-APPELLEES

ARGUED SEPT. 29, 1982

DECIDED JAN. 19, 1983

REHEARING DENIED FEB. 14, 1983

Before ALDISERT and HIGGINBOTHAM, Circuit Judges, and MEANOR, District Judge*

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*Honorable H. Curtis Meanor, United States District Court for the District of New Jersey, sitting by designation.

OPINION OF THE COURT

A. LEON HIGGINBOTHAM, JR., Circuit Judge.

Since time immemorial it has been argued that "The King can do no wrong;" therefore, his subjects can neither complain of, nor be indemnified for, the "wrongs" of the King nor for the wrongs of the King's agents. In a different context, we are now asked to affirm a somewhat similarly archaic concept in favor of the United States government, regardless of its effect on innocent persons. Even though the agent of the Secretary of Health and Human Services[1] on *five* different occasions over a two and one-half year period wrongly advised a charitable health care provider that certain costs were reimbursable, and even though the health care provider in good faith made expenditures and *incurred obligations* in excess of $70,000 in reliance on the explicit advice of the agent of the Secretary, and even though the repayment of those "costs" may cause a significant diminution of home health care availability to ill and poor people in a rural medically underserved area, the Secretary now seeks to hold the health care provider liable for recoupment of the reimbursed costs. In effect, the government seems to argue that: "We, just like the King and his agents, can do no wrong, regardless of the grievous consequences we cause innocent people."[2] The issue we must decide is whether, on the facts of this case, the Secretary can be estopped from recouping monies from the very party that was induced, by the government agent's totally erroneous advice, into incurring the expenses for which the reimbursements were made.

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[1] This department was called the Department of Health, Education, and Welfare when this cause of action arose. We will refer to this Department by its present name, the Department of Health and Human Services.

[2] In the government's brief, counsel phrased the issue as follows:

> It is a well established principle of law that estoppel can not be asserted against the government on the basis of alleged misinformation furnished by an employee or agent of the government, even if there is detrimental reliance on that information.

Appellee's Brief at 26.

Appellants, Community Health Services of Crawford County, Inc. (CHS), a nonprofit corporation and Ada Werner, Frank E. Werner, and Shirley Sorger, individuals within the county who utilize CHS' services, ask this court to set aside the summary judgment order of the United States District Court for the Western District of Pennsylvania. Plaintiffs/Appellants have filed two separate suits against the Secretary and its agent, the Travelers Insurance Companies (Travelers). Appellants claim that the decisions of the Provider Reimbursement Review Board (PRRB) and the Secretary, which allowed recoupment of overpayments to CHS under Medicare cost reimbursement procedures, were erroneous. Though appellants assert several grounds for reversal, we agree only that the District Court erred in finding that the United States cannot be estopped from recouping the alleged overpayment. Under the egregious facts of this case and in view of the affirmative misconduct of the government's agent—Travelers—we will reverse the judgment of the district court.

I.

CHS is a charitable health care provider incorporated under the laws of Pennsylvania. In 1966 it entered into an agreement with the Secretary whereby CHS agreed to provide home health care services to eligible individuals under the Medicare provisions of the Social Security Act.[3] The Secretary agreed to reimburse CHS for reasonable costs of such services. In April, 1975, CHS entered into contracts with the Mercer County Consortium Services, Inc. by which CHS was to employ participants in a program established under the Comprehensive Employment and Training Act of 1973[4] (CETA) which is designed to provide job training and experience for unemployed individuals to enhance their future employability. Under the terms of the CETA grants, "CHS was to employ program participants furnished by the regional CETA administration, and it was to

[3] 42 U.S.C. § 1395 *et seq.*

[4] 29 U.S.C. § 801 *et seq.*

be reimbursed for the salaries and fringe benefits paid to those employees."[5]

John C. Wallach, CHS' administrator, testified that CETA workers enabled the agency to expand the range of services it provided and to meet the mushrooming demand for health services in the economically depressed and impoverished rural area in which it functioned.[6] CHS [*sic*] had designated the county that CHS serves as a medically underserved area.[7] It is understandable that from 1975 to 1978 CHS' units of service burgeoned from just under 4,000 to 81,000 per year. In 1979 they increased to over 100,000 units of service.[8] CETA funds became a critical source for financing this expansion because CHS was otherwise dependent upon Medicare reimbursements and charitable contributions.[9] In 1975-1976, CETA grants of $53,402 represented 25% of CHS' budget: in 1976-1977 CETA grants of $81,141 represented 24% of its budget; in 1977-1978, CETA grants of $104,524 represented 18%.[10]

Medicare regulations provide that revenue received by providers in the form of donor-restricted grants, or gifts that must be used to pay designated operating expenses, must be set off against the expenses submitted to Medicare for reimbursement in the provider's cost report.[11] However, the *Provider Reimbursement Manual* at § 612 provides an exception to required offsets known as "Seed Money Grants."[12] "Seed Money" is defined in § 612.2 as "[g]rants designated for the development of new health care agencies or for expansion of services of established

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[5] *Community Health Services, Inc.* v. *Harris*, No. 80-56, Memorandum Opinion, Joint Appendix at 186a.

[6] Transcript of Proceedings before the PRRB (Transcript) at 094-095, 0100-0103, 0106-0108, 0123-0128.

[7] *Id.* at 095.

[8] *Id.* at 0128.

[9] *Id.* at 099.

[10] *Id.* at 0132, 0136.

[11] 42 C.F.R. § 405.423(a).

[12] Quoted in *Community Health Services* v. *Harris*, Joint Appendix at 188a-189a.

agencies. . . ."[13] Thus, the critical question arose as to whether the CETA grants had to be offset against expenses CHS submitted to Medicare for reimbursement.

The administrative structure established under Medicare made it quite difficult for CHS to get an answer to the above question. The administrative process precluded CHS from presenting an inquiry directly to the Secretary. Rather, it was required to consult a fiscal intermediary appointed by the Secretary to serve as his agent. The intermediary's primary duty involved processing claims and payments to providers such as CHS. The intermediary was required statutorily to relay information and instructions from the Secretary to providers and to serve as a channel of communication from providers to the Secretary.[14] Consequently, Wallach presented the question of the appropriate treatment of CETA funds to the intermediary, appellee Travelers Insurance Companies. From 1975 to August 1977, Wallach discussed this issue with Michael Reeves, Travelers' Medicare Manager, on five separate occasions.[15] On each occasion, Reeves advised Wallach that Medicare would not offset the CETA grants against reimbursable costs because they qualified as a "seed money" exception to reimbursement offset as provided in § 612.2 of the *Provider Reimbursement Manual*.[16] CHS prepared its cost reports without offsetting its CETA grants from its reimbursable costs, and Travelers approved CHS' reports for the years 1975, 1976 and 1977. CHS used this additional money to finance the expansion of the health care services it provided to Medicare beneficiaries.[17]

During the years that CHS inquired into the treatment of CETA grants, the Secretary had neither formulated nor promulgated an official policy on the treatment of CETA funds. Administrative procedures applicable to this situation obliged Reeves to refer CHS' inquiries to the Health

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[13] *Id.* at 188a.

[14] 42 U.S.C. § 1395h.

[15] Transcript at 0146.

[16] *Id.* at 0104-0105, 0146-0147.

[17] *Id.* at 0107-0108, 0110-0114.

Care Financing Administrator. Consequently, Reeves was making a policy judgment in his own discretion in advising CHS that CETA funds were seed money and did not have to be offset. It was not until August 4, 1977 that he finally requested instructions about the treatment of CETA grants from the Philadelphia office of the Department's Bureau of Health Insurance as Reeves testified he was required to do under administrative procedures.[18]

The instructions Reeves received from Robert C. Griffith, the Program Officer of the Health Care Financing Administration, contradicted the advice Reeves had given to CHS. Griffith declared that CETA funds did not qualify as seed money and were therefore to be offset against the provider's reimbursable costs.[19] CHS was advised of this instruction by letter dated October 7, 1977 and personally by Reeves on November 9, 1977.[20]

Statutory procedures[21] authorize the Secretary to periodically review providers' cost reports. Thus, a determination made by an intermediary may be reopened and revised if, within three years after notice of the intermediary's determination, the Secretary notifies the intermediary that its determination is inconsistent with applicable law, regulations or general instructions of the Secretary.

Claiming authority under 42 C.F.R. § 405.1885, the Secretary reopened CHS' cost reports for 1975, 1976 and 1977 to recoup the CETA funds he claimed should have been offset against the costs Medicare reimbursed for those years. Beginning in May 1978, Travelers issued Notices of Program Reimbursements to recapture from CHS the following amounts: for the cost year ending October 31, 1975, $7,694.00; for the cost year ending October 31, 1976, $32,460.00; for the cost year ending October 31, 1977, $31,326.00. The total for the three years, $71,480, was to be offset against Medicare reimbursements owned to CHS

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[18] *Id.* at 0179.

[19] *Id.* at 0276.

[20] *Community Health Services, Inc.* v. *Harris*, Joint Appendix at 187a.

[21] 42 U.S.C. § 1395g(a), 42 C.F.R. § 405.1885.

for services it had provided to Medicare beneficiaries.[22] The Secretary demanded that CHS return these alleged overpayments pursuant to 42 C.F.R. § 405.1885. CHS filed a civil action[23] against the Secretary and Travelers requesting the district court to enter a Temporary Restraining Order and an injunction claiming that the Secretary's and Travelers' actions were unlawful and would bankrupt it and force it to cease providing health services to its beneficiaries. Three beneficiaries joined CHS as plaintiffs.[24] The district court granted plaintiffs' petition for a Temporary Restraining Order against the Secretary and Travelers.[25] CHS then pursued administrative remedies through an appeal from the Secretary's decision filed with the PRRB. On November 13, 1979, by stipulation of counsel, the Secretary agreed to cease recouping any of the al-

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[22] Transcript at 0619-0621.

[23] *Community Health Services* v. *Califano*, No. 78-74-B, Joint Appendix at 8a-19a.

[24] These beneficiaries made the following claims: Ada and Frank Werner asserted that, as beneficiaries under the Medicare Act, they had accrued a vested right to services by virtue of their payments into the Social Security system and supplementary medical insurance programs for the aged and disabled. As beneficiaries, they had been, and were likely to become again, recipients of services provided by CHS under the Medicare Act.

Shirley Sorger claimed to be a current beneficiary with an accrued right to CHS' services under the Medicare Act by virtue of a disability due to multiple sclerosis.

In support of their petition, the beneficiaries asserted:

> 23. If CHS is forced to curtail services because of defendants' arbitrary, unlawful and capricious acts and determinations, the individual plaintiffs herein will be deprived of their property interest and right to services under the Medicare Act. This deprivation is likely to cause the individual plaintiffs to be forced out of their homes in order to obtain adequate medical care now provided by CHS. Further, since Crawford County is substantially classified as a "Medically Underserved Area" by the Secretary (see Exhibits "D", "E" and "F"), the individual plaintiffs are likely to be caused severe medical injury, including possibly death, because of the lack of medical facilities and services. Joint Appendix at 12a, 18a.

[25] *Id* at 69a-71a.

leged overpayments, and CHS agreed to a stay in its civil action.[26].

A hearing was held before the PRRB on January 22, 1980, and the Board rendered its decision on March 12, 1980.[27] The PRRB concluded that the CETA grants did not come within the "seed money" exception to reimbursement offsets and that CHS would have to return these monies for the cost years 1976 and 1977. CHS was not required to return those for the cost year 1975 since the notice of reopening was improper and could not be reissued because the three year statutory limitation on reopening the 1975 cost report had expired. The PRRB's decision thus reduced the alleged overpayment to $63,839.

CHS then brought Civil Action No. 80-56B in the United States District Court on April 10, 1980 to review the PRRB's determination of the $63,839 for the cost years 1976 and 1977.[28] On the Secretary's unopposed motion, the Court consolidated civil action No. 78-74B with this action.[29] The parties filed motions for summary judgment. On December 29, 1980, the court granted the Secretary's and Travelers' motion for summary judgment and denied that of CHS and the individual beneficiaries.[30]

On January 14, 1982, appellants filed their notice of appeal. They claim, *inter alia*, that the Secretary should be estopped from recovering the overpayments because his affirmative misconduct induced CHS to include in its cost reports expenses that were covered by CETA grants. We agree with the appellants.

II.

Justice Marshall recently wrote in a dissent that the Supreme Court assumes "that we will know an estoppel when we see one—[but the majority] provides inadequate guid-

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[26] *Id.* at 107a-108a.

[27] Case No. 78-215, Decision 80-D12. The PRRB's decision is in Transcript at 0012-0017.

[28] CHS' complaint is in Joint Appendix at 94a-103a. The answer is in Joint Appendix at 104a-105a.

[29] *Id.* at 109a.

[30] *Id.* at 185a-196a.

ance to the lower courts in an area of the law that . . . is far from settled."[31] As we seek to ascertain and reconcile the conflicting rationales proffered for application or rejection of the estoppel doctrine in a broad variety of cases involving the government, like Justice Marshall, we find this issue far from settled. Thus, we will first explain the doctrine's historical underpinnings, then trace the recent doctrinal developments and conclude by applying what we believe are the most controlling and compelling precedents to the facts of this case.

The doctrine of estoppel is used to prevent a litigant from asserting a claim or a defense against another party who has detrimentally changed his position in reliance upon the litigant's misrepresentation or failure to disclose some material fact.[32] The elements of estoppel ordinarily include a misrepresentation or omission of a material fact by one party; reasonable reliance on that misrepresentation by the other party; and detriment to the other party.[33]

Courts traditionally have been reluctant to apply estoppel against the government. Considerations of sovereign immunity, separation of powers and public policy, such as the fear of binding the government by the improper acts of its agents because of possible resultant fraud and collusion or the severe depletion of the public treasury, explain this judicial reluctance.[34] However, with the great expansion of governmental operations, courts have recently shown a greater willingness to apply estoppel against the government in specific circumstances.[35]

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[31] *Schweiker* v. *Hansen*, 450 U.S. 785, 792, 101 S.Ct. 1468, 1473, 67 L.Ed.2d 685 (1981) (Marshall, J., dissenting).

[32] *Portmann* v. *United States*, 674 F.2d 1155, 1158 (7th Cir. 1982).

[33] *Brown* v. *Richardson*, 395 F. Supp. 185, 191 (W.D.Pa.1975).

[34] See the general discussion of the doctrine of governmental estoppel in *Portmann* v. *United States*, 674 F.2d at 1158-60; K. Davis, Administrative Law Treatise §§ 17.01, 17.03-17.04 (2d Ed. 1 Supp. 1982); Note, Equitable Estoppel of the Government, 79 Colum. L. Rev. 551 (1979).

[35] *See, United States* v. *Fox Lake State Bank*, 366 F.2d 962 (7th Cir. 1966); *Semaan* v. *Mumford*, 335 F.2d 704 (D.C.Cir.1964); *Wal-*

Although the Supreme Court continues to manifest reluctance to apply estoppel against the federal government, it has acknowledged that estoppel may be properly applied against the government under certain circumstances.[36] However, it "has never decided what type of conduct by a Government employee will estop the Government from insisting on compliance with valid regulations governing the distribution of welfare benefits."[37]

Several circuits, including this circuit, have held that "affirmative misconduct" on the part of a government official will entitle petitioner to invoke estoppel against the government.[38] While the Supreme Court has not explicitly adopted the theory of estoppel because of the affirmative misconduct of a governmental official, the Court has given it tacit recognition in decisions holding that the complained of action did not rise to affirmative misconduct warranting the application of estoppel. For example, in *INS* v. *Hibi*,[39]

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sonavich v. *United States*, 335 F.2d 96 (3d Cir. 1964); *Simmons* v. *United States*, 308 F.2d 938 (5th Cir. 1962).

[36] *Schweiker* v. *Harsen*, 450 U.S. at 785, 101 S.Ct. 1468.

[37] *Id.* at 788, 101 S.Ct. at 1471.

[38] *See, Mendoza-Hernandez* v. *INS*, 664 F.2d 635, 639 (7th Cir. 1981); *Yang* v. *INS*, 574 F.2d 171, 174-75 (3d Cir. 1978); *Corniel-Rodriguez* v. *INS*, 532 F.2d 301, 306-07 (2d Cir. 1976); *Santiago* v. *INS*, 526 F.2d 488, 491-93 (9th Cir. 1975).

[39] 414 U.S. 5, 94 S.Ct. 19, 38 L.Ed.2d 7 (1973). This case involved a petition for citizenship brought by a native of the Phillipines who had served in the United States Army during World War II. The Nationality Act of 1940 provided that non-citizens such as Hibi, who had served in the armed services during World War II, could be naturalized without the usual requirements of residency and language proficiency. However, applicants were required to file naturalization petitions by December 31, 1946. Congress authorized the appointment of naturalization officers who travelled to various countries to assist such applicants. The immigration officer who was assigned to the Phillipines in 1945 was removed shortly thereafter. Hibi first arrived in the United States in 1964 and filed a petition for naturalization pursuant to the Naturalization Act of 1940. He argued that the government should be estopped from enforcing the December 31, 1946 deadline because of its failure to publicize his rights under the 1940 statute and its failure to station in the Phillipines a naturalization representative for the time such rights were available to him.

the Court asserted that, "while the issue of whether 'affirmative misconduct' on the part of the Government might estop it from denying citizenship was left open in *Montana* v. *Kennedy*, 366 U.S. 308, 314, 315, 81 S.Ct. 1336, 1340-1341, 6 L.Ed.2d 313 (1961), no conduct of the sort there adverted to was involved here."[40] Just last year the Court similarly held that a Social Security Administration employee's erroneous statement that a woman was ineligible for benefits, and his failure to advise her to apply for them, was less than affirmative misconduct and did not estop the Administration from denying her retroactive benefits.[41] The Court's rationale for this result is, *inter alia*, that the employee's failure to advise the woman was a breach of a manual guideline that did not constitute a regulation and did not have legally binding force. Moreover, petitioner failed to satisfy the procedural requirement of filing an application. Thus, petitioner failed to fulfill her statutorily imposed duty essential to receiving benefits.

Schweiker v. *Hansen*, *supra*, implies that one example of affirmative misconduct is the failure of a government employee to perform an act that is required by law. The Second Circuit explicitly stated what the Supreme Court implied. In *Corniel-Rodriguez* v. *I.N.S.*,[42] the court reversed a deportation order of an alien who inadvertently violated the Immigration and Nationality Act because American consular officers had failed to provide her with certain crucial information. Petitioner received an immigrant visa as the unmarried child of a United States resident, and the American consul failed to warn her that her visa would be automatically voided if she married before arriving in the United States. The official State Department regulations required the consular officer to provide this warning upon issuing the visa to petitioner. She married three days before she left her homeland, and the Immigration and Naturalization Service demanded her deportation after her arrival in the United States. The court found that the officer's

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[40] *Id.* at 8, 94 S.Ct. at 21.

[41] *Schweiker* v. *Hansen*, 450 U.S. at 788-89, 101 S.Ct. at 1470-1471.

[42] 532 F.2d at 306-07.

failure to comply "with an affirmatively required procedure" was an act of affirmative misconduct.[43] The court estopped the government from deporting the alien and declared that it refused "to sanction a manifest injustice occasioned by the government's own failures."[44]

While *Corniel-Rodriguez* found affirmative misconduct in the failure to perform a regulation-mandated action, other decisions emphasized equitable considerations in applying estoppel when government employees engaged in conduct on which petitioners relied to their detriment. Thus, the Seventh Circuit estopped the federal government from bringing an action under the Civil False Claims Act against a bank that had relied upon the advice of federal agents in preparing certain disputed claims applications.[45]

The Ninth Circuit applied estoppel against the government although the representation relied upon was unauthorized.[46] The facts in that case involved the submission of a noncompetitive oil and gas lease bid to a regional Land Management office. The Land Manager rejected that bid because he interpreted an Interior Department decision as prohibiting the issuance of leases where the bid designates unequal interests as did the bid in *Brandt*. The Land Manager's decision provided that the applicants could resubmit their corrected bid without losing the priority of their original bid. The Secretary of the Interior later ruled that the Land Manager's statement concerning continuity of priority of the original bid was unauthorized and wrong. He awarded the lease to another applicant who submitted his bid before applicants had resubmitted their bids. In estopping the Secretary from disavowing the Land Manager's unauthorized statement, the court declared:

> Not every form of official misinformation will be considered sufficient to estop the government.... Yet some forms of erroneous advice are so closely connected to the basic fairness of the administrative decision

[43] *Id.*

[44] *Id.* at 307.

[45] *United States* v. *Fox Lake State Bank*, 366 F.2d at 962.

[46] *Brandt* v. *Hickel*, 427 F.2d 53, 56-57 (9th Cir. 1970).

> making process that the government may be estopped from disavowing the misstatement.[47]

The court concluded that "estoppel . . . can properly be applied . . . where the erroneous advice was in the form of a crucial mistatement in an official decision."[48]

III.

The precepts and rationales of the aforementioned cases require this court to estop the government from recouping the reimbursements paid to CHS for expenses it incurred in employing CETA workers. The record shows that CHS was induced into submitting those expenses without offsetting the CETA grants by the affirmative instructions of the Secretary's agent, Travelers Insurance Companies. Not once, but on five separate occasions spanning over two years, Travelers advised CHS not to offset the CETA grants because they qualified as seed money exceptions to the offset requirements. Those instructions were affirmed by Travelers' approval of CHS' cost reports for those years.

It was reasonable for CHS to follow Travelers' instructions in this situation. CHS acted reasonably because it was adhering to the administrative process mandated by Medicare. Consequently, CHS was harmed by diligently fulfilling its government-imposed duties within the Medicare system. Moreover, the source of the harm suffered by CHS is the intermediary's failure to pass on CHS' inquiry to the proper authority and its providing the answer itself. These conclusions are supported by the findings of the PRRB:

> [T]he Board would like to acknowledge the Provider's argument concerning the role of the fiscal intermediary. The Regulations succinctly state that 'an important role of the fiscal intermediary, in addition to claims processing and payment and other assigned responsibilities, is to furnish consultative services to providers in the development of accounting and cost-finding procedures which will assure equitable payment under the program' [42 CFR 405.401(e)]. However, it should be

[47] *Id.* at 56.

[48] *Id.* at 57.

> emphasized that the role of the intermediary is not to establish the principles of reimbursement. This is the responsibility of the Secretary. Although the Provider acted in good faith in not offsetting salaries and fringe benefits by CETA funds, advice by the Intermediary cannot be a substitute for the opinion of the Secretary.[49]

Thus, CHS acted in good faith; Travelers was not authorized to decide whether the CETA grants should have been offset; this decision should have been made by the Secretary.

In light of those findings, the PRRB, and the District Court in affirming the PRRB's decision, was clearly erroneous in concluding that CHS unreasonably relied upon Travelers' instructions and in attributing liability to CHS. To hold CHS liable would place it in an untenable position. Appellants' brief expresses the dilemma posed by the decisions below:

> Query, if a provider must obtain the opinion of the Secretary, what is the provider supposed to do when the Intermediary fails to communicate a provider's request for that opinion? Is a provider supposed to circumvent the Secretary's mandated procedures? Further, what is the provider's remedy when the Intermediary acts in violation of the Intermediary's statutory requirement to serve as a channel of communications? Finally, how is a provider to know whether the information it is receiving is from the Intermediary or the Secretary?[50]

Appellants' argument then identifies the import of the District Court's decision:

> In view of these questions, if the District Court's construction of the reasonable reliance estoppel element is permitted to stand, it will drastically alter the reimbursement process under the Medicare Act contrary to Congressional intent. Under the District Court's construction, a provider subjects itself to substantial harm by dealing with an Intermediary at all. If the Intermediary decides to act without obtaining the

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[49] Joint Appendix at 93a.

[50] Appellant's Brief at 26.

> Secretary's opinion, as Travelers did here, the Secretary can then avoid liability by simply disavowing any responsibility for information given to the detriment of the provider. This is precisely what the Secretary is attempting to do here. Thus, a provider has no reason to deal with an Intermediary. The risk is too great. The District Court's ruling may cause providers to abandon Intermediaries in favor of direct dealing with the Secretary to avoid this risk thereby defeating the statutory reimbursement procedures and mandating a larger government workforce at a time when substantial reductions are mandated.[51]

We find that Travelers' unauthorized and erroneous advice to CHS is analogous to that of the Land Manager in *Brandt* v. *Hickel*, *supra*, which the court in that case found to be "so closely connected to the basic fairness of the administrative decision making process that the government may be estopped from disavowing the misstatement."[52]

Therefore, the intermediary's advice was not only erroneous, it constituted affirmative misconduct in relation to CHS. Reeves testified at the PRRB hearing that he knew of no official policy concerning the CETA grants at the time Wallach asked for guidance.[53] He also testified that the procedure intermediaries followed in getting answers to questions that are not covered in the administrative guidelines is to pass them on to the regional office of the Bureau of Health.[54] Although CHS fulfilled its administrative duties in presenting its question to Travelers, Travelers knowingly violated statutory and procedural guidelines in failing to communicate it to the proper authority within HHS from June 1975 to August 1977. Reeves deliberately chose instead to make that policy decision on his own. Reeves finally did forward CHS' inquiry to the Bureau of Health in August 1977. Had he done this in the first in-

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[51] *Id.* at 26-27.

[52] *Brandt* v. *Hickel*, 427 F.2d at 56.

[53] Transcript at 0197-0198.

[54] Transcript at 0179. Travelers was obliged by statute and by its contract with the Secretary to "serve as a channel of communication from providers of services to the Secretary." 52 U.S.C. § 1395h (a)(2)(A) and Transcript at 0289.

stance CHS would not have been misled. The harm to CHS was thus caused by the failure of the government's agent to perform a legally binding procedure.

It appears, therefore, that the intermediary's behavior in this case is similar to the consul officer's failure to comply "with an affirmatively required procedure" that the Second Circuit held constituted affirmative misconduct necessitating the application of estoppel against the government.[55] To impose liability on CHS for its good faith compliance with Medicare prescribed procedures and to allow the government to escape liability created by its agent's violation of those procedures would, in effect, repudiate the Medicare administrative process that was established by Congress.

This case is distinguishable, therefore, from five recent cases in which the Supreme Court found that the estoppel doctrine did *not* apply to the government.[56] Those cases provide no precedential support for the preclusion of the estoppel doctrine in this case.

In the earliest case, *Federal Crop Insurance Corp.* v. *Merrill*, *supra*, respondents brought an action to enforce a contract they entered into with a government agency, the Federal Crop Insurance Corporation, through its local agent to insure spring wheat that they were planting on winter wheat acreage. However, the Corporations' Wheat Crop Insurance Regulations clearly "precluded insurance coverage for spring wheat reseeded on winter wheat acreage."[57] The Court declared:

> not only do the Wheat Regulations limit the liability of the Government as if they had been enacted by Congress directly, but they were in fact incorporated by

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[55] *Corniel-Rodriguez* v. *INS*, 532 F.2d at 306-07.

[56] *Immigration and Naturalization Service* v. *Miranda*, ___ U.S. ___, 103 S.Ct. 281, 74 L.Ed.2d 12 (1982); *Schweiker* v. *Hansen*, *supra*; *INS* v. *Hibi*, *supra*; *Montana* v. *Kennedy*, *supra*; *Federal Crop Insurance Corporation* v. *Merrill*, 322 U.S. 380, 68 S.Ct. 1, 92 L.Ed. 10 (1947).

[57] *Federal Crop Insurance Corporation* v. *Merrill*, 332 U.S. at 386, 68 S.Ct. at 4.

reference in the application, as specifically required by the Regulations.[58] [footnotes omitted]

The Supreme Court refused to enforce the contract and held the government liable on respondents' claim for crop damage due to drought. It held that "the Wheat Crop Insurance Regulations were binding on all who sought to come within the Federal Crop Insurance Act, regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance."[59]

Perhaps the dividing line between the majority and the dissent in the instant case is our different readings of the *Merrill* case. We would not categorize the dissent's construction of that case as implausible, but we believe that the facts of *Merrill* are so different from those of this case that *Merrill* is not controlling and possibly irrelevant. With a closely divided court in *Merrill* the majority of five indicated that had the plaintiffs only gone to the basic documents—the regulations—they would have been able to ascertain the limited coverage under the Wheat Crop Insurance Regulations. In contrast to *Merrill*, in this case there is no "clear meaning of the regulation;" in fact there was no regulation in force at the time. Thus, there was no source to which CHS could have gone to ascertain whether the government agent's advice was wrong. This, we think, is the critical difference that makes *Merrill* inapplicable to the instant case.

In *INS* v. *Miranda*, *supra*, petitioner was a citizen of the Philippines who came to the United States and married a United States citizen after his temporary visitor's visa expired. He filed an application with the Immigration and Naturalization Service to adjust his status to that of a permanent resident alien. His wife, whose name is Milligan, simultaneously filed a petition requesting the INS to issue an immigrant visa to Miranda. The Court noted that, because § 245(a) of the Immigration and Naturalization Act conditions the granting of permanent resident status to an alien on the immediate availability of an immigrant visa, Milligan's petition would have satisfied this condition.

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[58] *Id.* at 385, 68 S.Ct. at 3-4.

[59] *Id.*

However, the INS failed to act on Miranda's petition and Milligan's application for eighteen months. During this time, Miranda and Milligan were divorced. Following the divorce Milligan withdrew her application. The INS thereafter denied Miranda's petition and ordered his deportation because he was no longer eligible for a permanent immigrant visa owing to his divorce. Miranda appealed on the theory that the government should be estopped from deporting him because its failure to act on his petition and Milligan's application for eighteen months was so unreasonable, unfair and unjust that it was affirmative misconduct.

The Supreme Court rejected Miranda's appeal. It found that the INS' failure to process Milligan's application more promptly did not amount to affirmative misconduct. Its reason for this conclusion is that Miranda failed to present evidence to show that the eighteen months that INS used to investigate the validity of Miranda's marriage was unwarranted. Therefore, the evidence did not establish that the government failed to fulfill its duty.

Unlike *Miranda*, the government agent's misconduct in this case is clear. The duty imposed upon him by statute and by Medicare regulations was unambiguous; this duty was known to him; he failed to peform it.

In *Schweiker*, the Court in referring to Mr. Connelly, field representative of the Social Security Administration stressed that:

> at worst, Connelly's conduct did not cause respondent to take action, ... or fail to take action, ... that respondent could not correct at any time.[60]

Unlike *Schweiker*, the advice of the government agent in this case caused CHS to take action—to provide to the ill and to the poor more medical services than it otherwise would have because of the additional financial resources which CETA grants made possible if reimbursement of CETA grants was not required.[61] CHS failed to eliminate those additional human services because, over a period of two and a half years, it relied on the explicit assurances of

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[60] *Schweiker* v. *Hansen*, 450 U.S. at 789, 101 S.Ct. at 1471.

[61] Transcript at 0146-0147.

the only authorized representative of the government with whom CHS was supposed to consult—Mr. Reeves of Travelers. Finally, this is an error that CHS "could not correct at any time." It is irremediable because the government is not simply requesting prospective changes; instead, it is pressing for the recoupment of funds that have already been spent and which are not otherwise available. The testimony in this case suggests that the "correction" could very well mean that CHS will close its doors or drastically reduce its services to ill and poor people if it is forced to repay the Secretary amounts equal to CETA grants CHS received. In fact, the trial judge, in granting the Temporary Restraining Order, held:

> 4. That CHS is a non-profit organization whose operation is dependent upon government funding and which has exhausted its borrowing capability and has no other source of funds with which to meet its payroll on August 15, 1978, other than the aforesaid funds due it from HEW;
>
> 5. That there is danger of immediate and irreparable injury being caused to plaintiff CHS, its employees and to the public which they serve, for the reason that the actions of the defendant Secretary will likely cause CHS to cease or severely curtail operations as a home health service agency, thereby threatening the health and lives of the individual plaintiffs and others similarly situated;[62]

In the earliest case, *Montana* v. *Kennedy; supra*, petitioner sought to estop the government from deporting him after residing in the United States for over fifty years. In resisting his deportation in 1958, petitioner argued, *inter alia*, that he was born outside of the United States because his mother had been prevented from leaving Italy prior to his birth by an American Consular Officer in Italy who mistakenly told his mother that she could not return to the United States in her pregnant condition and refused to issue her a passport while she was pregnant.[63] Petitioner as-

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[62] Joint Appendix at 70a.

[63] *Montana* v. *Kennedy*, 366 U.S. at 314, 81 S.Ct. at 1340.

serted that the government should be estopped from deporting him "because of its own misconduct."[64]

The Court rejected petitioner's claim. It noted that the law was clear in 1906, and neither the United States nor Italy required an American passport to leave Italy and to travel to the United States. Since petitioner's mother was permitted by United States and Italian law to leave Italy, the Supreme Court characterized the consular officer's statement as merely "well meant advice" that a pregnant woman "cannot [return to the United States] in that condition."[65] Consequently, the court held that the advice fell "far short of misconduct."[66] Petitioner's mother could have ascertained her legal rights by independent inquiry. Unlike *Montana*, appellant CHS in the case before us had no alternative means of ascertaining the status of CETA grants. No regulation, congressional directive or administrative guideline existed that determined whether or not CETA grants should be offset against Medicare reimbursements. Therefore, we find that the erroneous advice that was given to CHS by the *only* governmental source of information available to it is affirmative misconduct under the unique circumstances of this case.

Finally, in *INS* v. *Hibi*, *supra*, estoppel was denied because the Court did

> not think that the failure to fully publicize the rights which Congress accorded under the Act of 1940, or the failure to have stationed in the Phillipine Islands during all of the time those rights were available an authorized naturalization representative, can give rise to an estoppel against the government.[67]

In contrast to *Hibi*, *supra*, the governmental officer authorized by the statute to assist petitioner in the instant case to ascertain its rights was available; petitioner consulted him; and the officer gave erroneous advice on which petitioner relied to its great financial detriment. Moreover, the government conduct in *Hibi* was in the nature of an

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[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] 414 U.S. at 8-9, 94 S.Ct. at 21-22.

omission. Here, the governmental conduct was a clear act of commission which, on the facts of this case, rises to the level of affirmative misconduct.

IV.

The Court wishes to emphasize the injustice to CHS and the people it serves if it is required to refund the alleged overpayments. The extra monies were used to expand CHS' services to meet serious human needs. This case, therefore, is distinguishable from others that involve possible overtones of fraud or profiteering by submitting to Medicare inflated cost reports for unnecessary services. No one questions the reasonableness of the amounts paid to, or the necessity of employing CETA workers. The only people who profited were the weak, the lame and the ill who comprised CHS' impoverished and medically underserved beneficiaries. They would be the persons injured if CHS were required to repay the funds in question. In granting CHS' motion for a Temporary Restraining Order, the District Court recognized this harm when it asserted that recoupment of the CETA funds "will likely cause CHS to cease or severely curtail operations as a home health service agency, thereby threatening the health and lives of the individual plaintiffs and others similarly situated."[68] This Court, like the Second Circuit, refuses to sanction such a manifest injustice occasioned by the Government's own misconduct.[69]

With all due respect, we submit that the dissenting opinion is quite wide of the judicial mark in at least two respects. First, it alleges that we have been "snared by the trap" of "emotion and ideology" because we "approve ... the social program involved" and that we would not have "countenanced governmental estoppel" if we were merely dealing with "a defense contractor" claiming to retain seven million dollars. Dissenting opinion at 628, n.1. Candidly we believe that under our system of law all litigants are entitled to equal justice—whether wealthy or poor, whether defense contractors or non-profit health agencies, whether

[68] Joint Appendix at 70a.

[69] *Corniel-Rodriguez* v. *I.N.S.*, 532 F.2d at 307.

stockholders or medicare patients. Necessarily, when determining the issue of detrimental reliance we had to discuss the facts—thus the plight of the Community Health Services, their economic injury, their reliance and the impact of the government's misrepresentation on both CHS and the ill persons whom they serve. The dissent, therefore, is simply incorrect in asserting that this decision is an unprincipled expression of "emotion and ideology." Whether it is a defense contractor or an eleemosynary institution is not critical. Our adjudication is predicated on our finding of the affirmative misconduct of the government's agent; the petitioner's injury and the petitioner's reasonable reliance upon the government's agent's advice.

Secondly, the dissenting opinion is based upon a novel, but erroneous statement of the law of governmental estoppel. The dissent asserts that the petitioner must qualify for a substantive entitlement before governmental estoppel lies. *None* of the cases cited by the dissent embrace this theory; none of these decisions turn on the fact that petitioner had, or did not have, a substantive entitlement. In none of the cases has the Supreme Court used the term "substantive entitlement," nor has the Supreme Court uttered the theory of the dissent under any other label. Nor are we aware of any cases in which substantive entitlement was a controlling factor. The dissent, therefore, errs in emphasizing substantive entitlement rather than the nature of the government agent's conduct and the petitioner's reasonable and detrimental reliance upon that conduct.

Indeed, the Supreme Court's decision in *Schweiker, supra*, as the decision here, turned on the nature of the government employees' conduct and whether the petitioner demonstrated reasonable, detrimental reliance. In *Miranda, supra*, the Supreme Court explicitly refused to apply estoppel against the government precisely because the governmental action fell "far short of"[70] affirmative misconduct. The decision the dissent identifies as controlling precedent in this case, *Federal Crop Insurance Corporation* v. *Merrill, supra*, actually turned on the reasonable-

[70] *INS* v. *Miranda*, ___ U.S. at ___, 103 S.Ct. at 281-282.

ness of respondents' reliance on the government agent's advice, not on whether they had a substantive entitlement to the insurance. The Court decided against respondents because it held them responsible for knowing that the Corporation's regulations precluded the insurance coverage for which they had applied. In all these cases, the question of whether petitioner had a substantive entitlement was not germane.

Moreover, this case does not present a question of substantive entitlement. We do not have to determine, and we do not decide, if petitioner would be entitled to the funds in question if the government could not be estopped from recouping them. This case presents instead a question of detrimental reliance upon the affirmative misconduct of a government agent. Whether or not CHS is otherwise entitled to the monies is not relevant. CHS expended monies because of and in reasonable reliance upon, an illegally made and erroneously founded decision of a representative of the government. Therefore, the government should not now be allowed to reclaim those monies.

CONCLUSION

We hold that the District Court erred in concluding that equitable estoppel does not lie against the Secretary of Health and Human Services on the facts of this case. We therefore will reverse the judgment of the district court which granted appellee's motion for a summary judgment and remand these proceedings to the district court with the direction that it grant appellant's petition to estop the Secretary from recouping the alleged overpayment.

MEANOR, District Judge, dissenting.

Part I of the majority opinion quite adequately sets forth the facts and I need not repeat them. I cannot, however, accept the majority's conclusion that the government is estopped from claiming reimbursement for the overpayment made here. I recognize that this case has sympathetic

overtones.[1] However, if there is any basis for estopping the government—an action that the Supreme Court has never expressly taken[2]—this case does not provide it.

It is true that, particularly in the last decade, the federal judiciary has increasingly applied estoppel against the government.[3] I do not believe, however, that the government may be estopped where the estoppel would render to the opponent a benefit to which he was never substantively entitled. It may be that a valid estoppel can lie where affirmative government misconduct[4] induces a procedural default,

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[1] In *Federal Crop Ins. Corp.* v. *Merrill*, 332 U.S. 380, 68 S.Ct. 1, 92 L.Ed. 10 (1947), the Supreme Court recognized that it was dealing with a case which involved sympathetic overtones. Indeed, the court stated that "[t]he case no doubt presents phases of hardship." *Id.* at 383, 68S.Ct at 2. Nevertheless, the court was not moved by this factor, and held that the government should not be estopped. *Id.* at 386, 68S.Ct. at 4. I believe that the majority in the instant case has been snared by the trap which the Court in *Merrill* managed to avoid. The majority has allowed emotion and ideology to enter into its decision. I am convinced that if this case involved a defense contractor who worked on a cost plus basis, and who claimed a right to retain seven million dollars, as opposed to the seventy thousand dollars involved in the instant case, the majority would never countenance government estoppel. In short, I believe that the majority was influenced by the fact that it approves the social program involved. This sort of reasoning results in ad hoc decision-making which more appropriately is left to Congress.

[2] The issue of government estoppel has arisen in six Supreme Court cases: *Immigration & Naturalization Serv.* v. *Miranda*, ___ U.S. ___, 103 S.Ct. 281, 74 L.Ed.2d 12 (1982); *Schweiker* v. *Hansen*, 450 U.S. 785, 101 S.Ct. 1468, 67 L.Ed.2d 685 (1981); *United States Immigration & Naturalization Serv.* v. *Hibi*, 414 U.S. 5, 94 S.Ct. 19, 38 L.Ed.2d 7 (1973); *Montana* v. *Kennedy*, 366 U.S. 308, 81 S.Ct. 1336, 6 L.Ed.2d 313 (1961); *Moser* v. *United States*, 341 U.S. 41, 71 S.Ct. 553, 95 L.Ed. 729 (1951); *Federal Crop Ins. Corp.* v. *Merrill*, 332 U.S. 380, 68 S.Ct. 1, 92 L.Ed. 10 (1947). In none of these cases has the Supreme Court *expressly* estopped the government.

[3] *E.g.*, *Corniel-Rodriguez* v. *Immigration & Naturalization Serv.*, 532 F.2d 301 (2d Cir.1976); *Brandt* v. *Hickel*, 427 F.2d 53 (9th Cir.1970); *Walsonavich* v. *United States*, 335 F.2d 96 (3d Cir.1964).

[4] It is not altogether clear whether affirmative misconduct is required to estop the government, or whether mere negligence will suffice. In *Moser* v. *United States*, 341 U.S. 41, 71 S.Ct. 553, 95 L.Ed.

thus depriving one of the substantive entitlement.[5] It may also be that the doctrine of estoppel properly can be used where affirmative government misconduct induces action which thereafter prevents one from qualifying for a substantive entitlement.[6] But I do not believe the government can be estopped where the result would be to give a benefit to which there never was any entitlement.

For me, *Federal Crop Insurance Corp.* v. *Merrill*[7] is controlling. Respondents there applied to the petitioner federal agency for crop insurance on 460 acres of spring wheat, 400 acres of which was to be reseeded winter wheat. Respondents were advised that the entire crop was insura-

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729 (1951), discussed in text *infra*, the Court upheld a grant of United States citizenship where the foreign citizen was not warned by the United States that by claiming military exemption he would lose his right to become a citizen. Thus, the government's negligence in failing to warn the foreign citizen prevented the government from denying the person citizenship. Although the Court disclaimed reliance upon an estoppel theory, many believe this to be an estoppel case. *See infra* note 10. Similarly, in *Corniel-Rodriguez* v. *Immigration & Naturalization Serv.*, 532 F.2d 301 (2d Cir.1976), the government's failure to warn was held sufficient to estop the government. Contrary to the majority's reading of subsequent Supreme Court cases, *see* majority opinion at 621, I believe that these cases indicate that something more than mere negligence is required before affirmative misconduct will be found. *E.g.*, *Schweiker* v. *Hansen*, 450 U.S. 785, 788-89, 101 S.Ct. 1468, 1470-1471, 67 L.Ed.2d 685 (1981) ("we are convinced that Connelly's conduct—which the majority conceded to be less than 'affirmative misconduct,'...—does not justify the abnegation of that duty"); *United States Immigration & Naturalization Serv.* v. *Hibi*, 414 U.S. 5, 8, 94 S.Ct. 19, 21, 38 L.Ed.2d 7 (1973) ("While the issue of whether 'affirmative misconduct' on the part of the Government might estop it from denying citizenship was left open in *Montana* v. *Kennedy*, ... no conduct of the sort there adverted to was involved here"); *Montana* v. *Kennedy*, 366 U.S. 308, 314-15, 81 S.Ct. 1336, 1340-1341, 6 L.Ed.2d 313 (1961). *See Oki* v. *Immigration & Naturalization Serv.*, 598 F.2d 1160, 1162 (9th Cir.1979).

[5] *E.g.*, *Miranda* v. *Immigration & Naturalization Serv.*, 638 F.2d 83 (9th Cir.1981) (United States citizenship jeopardized because petitioner married before entering country).

[6] *E.g.*, *Walsonavich* v. *United States*, 335 F.2d 96 (3d Cir.1964) (taxpayer lured into not filing refund claim and claim subsequently barred by statute of limitations).

[7] 332 U.S. 380, 68 S.Ct. 1, 92 L.Ed. 10 (1947).

ble and the insurance was issued. The entire crop was later destroyed by drought, and respondents learned that valid regulations precluded crop insurance for reseeded wheat. In refusing to estop the government from denying liability the Supreme Court stated:

> Whatever the form in which the Government functions, anyone entering into an arrangement with the Government takes the risk of having accurately ascertained that he who purports to act for the Government stays within the bounds of his authority. The scope of this authority may be explicitly defined by Congress or be limited by delegated legislation, properly exercised through the rule-making power. And this is so even though, as here, the agent himself may have been unaware of the limitations upon his authority.[8]

The Court further stated that the limitation of insurance coverage was pursuant to valid regulations, and that all persons are charged with knowledge of rules and regulations in the Federal Register.[9]

The facts of *Merrill* parallel those here. In both cases erroneous representations were made by government agents; in both cases there was reliance; and in both cases damage was incurred because of that reliance. Finally, in both cases there never was any entitlement to secure a benefit from the government. The only difference between *Merrill* and this case is that here the plaintiffs have received the funds in dispute, whereas in *Merrill* the insurance proceeds never were paid. I can think of no way in which this factual difference can lead to a principled distinction. It is also important to note that in *Merrill* the Court noted "the duty of all courts to observe the conditions defined by Congress for charging the public treasury."[10]

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[8] *Id.* at 384, 68 S.Ct. at 3.

[9] Subsequent cases, however, seem to hold that persons are not held to have knowledge of all statutes and regulations. *See, e.g. Moser* v. *United States*, 341 U.S. 41, 71 S.Ct. 553, 95 L.Ed. 729 (1951); *Corniel-Rodriguez* v. *Immigration & Naturalization Serv.*, 532 F.2d 301 (2d Cir.1976).

[10] 332 U.S. at 385, 68 S.Ct. at 3.

The Supreme Court has never, except perhaps in one instance, countenanced the use of estoppel against the government. *Moser* v. *United States*[11] may be analyzed as a case in which an estoppel was applied against the government, although the court did not rely on the doctrine. Moser, a Swiss citizen residing in the United States, applied during World War II for exemption from military service pursuant to a treaty between the United States and Switzerland. By statute it was provided that a claim of exemption from military service prevented such a claimant from becoming a citizen of the United States. The usual form on which such an exemption was claimed stated explicitly that the claim would bar the claimant from obtaining citizenship. The Swiss legation, however, took the position that such a bar from citizenship was inconsistent with the rights under the treaty. The State Department, together with Selective Service Headquarters and the Swiss legation, worked out a revised form which omitted reference to debarment from citizenship. Moser, who had claimed the exemption, was later granted citizenship after the district court explicitly found that, had he known his claim of exemption from military service would debar him from citizenship, he would have elected to serve in the armed forces of the United States. The Supreme Court upheld the grant of citizenship on the ground that Moser had not made an intelligent waiver of his right to obtain citizenship. The Court, however, expressly disclaimed reliance on an estoppel theory. Nevertheless, many courts and commentators believe that the *Moser* Court was in reality applying estoppel principles.[12] I believe the result in *Moser* to be correct, regardless of whether a waiver or estoppel theory is relied upon. In *Moser*, the Swiss citizen could easily have become an American citizen had he not claimed the exemption. Thus, the government misconduct induced action on the part of the Swiss citizen which prevented him from qualifying for a substantive entitlement. In this re-

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[11] 341 U.S. 41, 71 S.Ct. 553, 95 L.Ed. 729 (1951).

[12] *E.g.*, *Air-Sea Brokers, Inc.* v. *United States*, 596 F.2d 1008, 1011 (C.C.P.A.1979); K. Davis, Administrative Law Text 345 (3d ed. 1972).

spect, *Moser* differs from *Federal Crop Insurance* in that the respondent in the latter case had no substantive entitlement and was not deprived of qualifying for one.

One recent case is particularly instructive in analyzing the issue of government estoppel. In *Hansen* v. *Harris*,[13] the claimant became eligible for social security benefits in June 1974. The claimant failed to file a written application, however, because a Social Security Field Representative supplied her with misinformation, and did not urge her to file a written claim. The Court of Appeals for the Second Circuit held that the government was estopped from denying benefits in view of the government's misconduct. The court began its analysis with the proposition that "[t]he Government may sometimes be estopped from enforcing its rules, based on the conduct of its agents."[14] The court went on to distinguish between procedural requirements and substantive eligibility for the program in question. Thus, the question becomes whether "[i]t would fulfill the fundamental legislative goal to grant appellee the benefits she seeks."[15] Because the appellee was found to be substantively entitled to the benefits, the court of appeals held the government estopped from denying benefits. The court limited its holding to cases where "(a) procedural not a substantive requirement is involved and (b) an internal procedural manual or guide or some other source of objective standards of conduct exists and supports an inference of misconduct by a Government employee."[16] In his dissenting opinion, Judge Friendly indicated that *Federal Crop Insurance* mandated a holding that the federal government can *rarely* be estopped. Judge Friendly stated that to estop the government means that the door to the federal fisc is held wide open, and that government agents will have to follow every regulation to the last detail. As for the substance/procedure distinction, Judge Friendly found the ar-

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[13] 619 F.2d 942 (2d Cir.1980), *rev'd*, *Schweiker* v. *Hansen*, 450 U.S. 785, 101 S.Ct. 1468, 67 L.Ed.2d 685 (1981).

[14] *Id.* at 947.

[15] *Id.* at 948.

[16] *Id.* at 949.

gument to be hollow. Judge Friendly believed that all conditions on receiving benefits are substantive "in the sense that . . . they significantly affect the result, not 'merely the manner or means by which a right to recover . . . is enforced.'"[17]

In *Schweiker* v. *Hansen*,[18] the Supreme Court reversed the court of appeals in a per curiam opinion. The Court began its opinion by stating that it agreed with Judge Friendly, who, it must be remembered, stated that the government should rarely be estopped. The Court stressed "'the duty of all courts to observe the conditions defined by Congress for charging the public treasury.'"[19] The court found that the government agent's failure to comply with the Claims Manual by not recommending that the claimant file a written application did not constitute affirmative misconduct. As for the substance/procedure distinction, the Court stated:

> Finally, the majority's distinction between respondent's "substantiv[e] eligib[ility]" and her failure to satisfy a "procedural requirement" does not justify estopping petitioner in this case. Congress expressly provided in the Act that only one who "has filed application" for benefits may receive them, and it delegated to petitioner the task of providing by regulation the requisite manner of application. A court is no more authorized to overlook the valid regulation requiring that applications be in writing than it is to overlook any other valid requirement for the receipt of benefits.[20]

It is important to note that the Court did not reject the substance/procedure distinction. The Court merely stated that under the facts of this case, the substance/procedure distinction did not warrant estopping the government. The claimant, however, could be said to have had a substantive entitlement to benefits in 1974. The claimant was deprived

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[17] *Id.* at 957 (Friendly, J., dissenting) (quoting *Guaranty Trust Co. v. York*, 326 U.S. 99, 109, 65 S.Ct. 1464, 1470, 89 L.Ed. 2079 (1945)).

[18] 450 U.S. 785, 101 S.Ct. 1468, 67 L.Ed.2d 685 (1981).

[19] *Id.* at 788, 101 S.Ct. at 1470 (quoting *Federal Crop Insurance*, 332 U.S. at 385, 68 S.Ct. at 3-4).

[20] *Id.* 450 U.S. at 790, 101 S.Ct. at 1471-1472.

of those benefits because of the misrepresentations of the government. What the Supreme Court seems to be saying, however, is that the requirement that the application be written is substantive, not procedural, and that the claimant had no substantive entitlement because a written application was never filed. This was the position adopted by Judge Friendly. As far as the instant case is concerned, however, the Supreme Court opinion supports my analysis. The *Hansen* opinion in no way casts doubt upon my theory that where there is no substantive entitlement, the government cannot be estopped. Indeed, in *Hansen*, the court found no substantive entitlement, and therefore did not estop the government. What the *Hansen* Court in reality does is to define when there is a substantive entitlement. I stated earlier that a valid estoppel *may* lie where affirmative government misconduct induces a procedural default, thus depriving one of a substantive entitlement, or where affirmative government misconduct induces action which thereafter prevents one from qualifying for a substantive entitlement. The *Hansen* opinion casts doubt upon whether procedural defaults can be the basis of governmental estoppel where the default was caused by government misrepresentations. *Hansen* seems to indicate that such defaults act to deprive the claimant of any substantive entitlement. In any case, resolution of this issue must await another day. In the instant case there can be no doubt that the appellant never had any substantive entitlement. Under *Federal Crop Insurance* and *Hansen*, I believe that the government clearly cannot be estopped.

The issue of government estoppel has been considered by numerous courts of appeal. The majority relies heavily upon two cases in particular. In *Corniel-Rodriguez* v. *Immigration & Naturalization Service*,[21] the petitioner applied for a special immigrant visa, and the United States consulate in Santo Domingo issued such a visa on August 17, 1967. Once in the United States, deportation proceedings were commenced, however, because petitioner had been married three days before her departure from the Do-

[21] 532 F.2d 301 (2d Cir. 1976).

minican Republic. A provision of the Immigration and Nationality Act provides that the exemption for children of special immigrants[22] is unavailable if the alien is married at the time of application for the visa or at the time of admission into the United States.[23] A valid regulation states: "The consular officer shall warn an alien [issued a visa as a child], when appropriate, that he will be inadmissible as such an immigrant if he is not unmarried at the time of application for admission."[24] Contrary to this regulation, the United States consulate did not advise petitioner of the consequences of marriage before entry into the country. So as to avoid a "manifest injustice," the Court of Appeals for the Second Circuit estopped the government from deporting the petitioner.

In *Brandt* v. *Hickel*,[25] appellants submitted a non-competitive oil and gas lease offer to the Los Angeles office of the Bureau of Land Management. Because the issuance of leases is prohibited where the offer form designates unequal interests, the offer was rejected. Appellants were given the right to substitute within thirty days new order forms eliminating any reference to unequal interests without losing their priority. Because of this promise, appellants did not appeal the decision of the Bureau of Land Management. In reality, the promise that appellants would not lose their priority was not authorized by statute or regulation. The court of appeals held that the "crucial misstatement" in the official decision of the Bureau of Land Management was sufficient to estop the government. Thus, appellants were granted a right to appeal from the land office decision, and were thereby entitled to attempt to preserve their priority.

In discussing the above cases, the majority concentrates on the fact that there was affirmative misconduct and that equitable considerations mandated estopping the government. The majority, however, fails to acknowledge that in

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[22] 8 U.S.C. § 1182(a)(14)(1976).

[23] *See id.* § 1101(b)(1).

[24] 22 C.F.R. § 42.122(d) (modified in 1965).

[25] 427 F.2d 53 (9th Cir.1970).

both these cases the appellants had a substantive entitlement.[26] In *Corniel-Rodriguez*, the petitioner had a right to become an American citizen. Petitioner was deprived of this right by the government's failure to warn as to the consequences of marriage before entry into the country. In *Brandt*, appellants had a right to appeal the decision of the Bureau of Land Management. This right was lost, however, because of affirmative misrepresentation on the part of the government. The majority states: "We find that Travelers' authorized and erroneous advice to CHS is analogous to that of the Land Manager in *Brandt* v. *Hickel*, *supra*, which the court in that case found to be "so closely connected to the basic fairness of the administrative decision making process that the government may be estopped from disavowing the misstatement."[27] Fairness may have dictated that the government be estopped in *Brandt*. Fairness does not dictate that the government be estopped where, as in the instant case, the appellant never had any substantive entitlement to the benefits. Where no substantive entitlement exists, to estop the government amounts to no more than a court authorized raid on the public treasury. Thus, the cases relied upon by the majority provide no support for the notion that the government should be estopped where no substantive entitlement exists. It is true that there are some cases where the courts have estopped the government even though no substantive entitlement existed.[28] In my opinion, courts which have so held are simply wrong.

As stated earlier, I believe that the outcome in this case is controlled by *Federal Crop Insurance*. It seems to me that *Federal Crop Insurance* was recently reaffirmed by the Supreme Court in *Schweiker* v. *Hansen*. In *Hansen*,

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[26] Even under the *Hansen* definition of "entitlement," it is clear that appellants had substantive entitlements.

[27] Majority opinion at 623.

[28] *E.g.*, *United States* v. *Lazy FC Ranch*, 481 F.2d 985 (9th Cir. 1973); *Dana Corp.* v. *United States*, 470 F.2d 1032 (Ct.Cl.1972); *United States* v. *Georgia-Pacific Co.*, 421 F.2d 92 (9th Cir.1970); *Schuster* v. *Commissioner of Internal Revenue*, 312 F.2d 311 (9th Cir.1962)

the Court expressly agreed with the position taken by Judge Friendly in his dissenting opinion in the court of appeals. In his dissent, Judge Friendly adhered strictly to the precepts of *Federal Crop Insurance*. Indeed, Judge Friendly was of the opinion that the government should rarely be estopped. Although the Court in *Hansen* approved Judge Friendly's position, it is doubtful whether it meant to go as far as to say that the government can never be estopped, in view of the fact that the *Hansen* Court went on to find that no affirmative misconduct was involved.[29] Nevertheless, *Hansen* indicates that the Supreme Court views government estoppel with disfavor, and certainly provides no support for the majority opinion. Appellant in the instant case had no substantive entitlement, and thus under *Federal Crop Insurance* and *Hansen* the government cannot be estopped.

For the foregoing reasons, I respectfully dissent.[30]

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[29] Indeed, since *Hansen* at least one court of appeals has held the government estopped. *E.g.*, *Miranda* v. *Immigration & Naturalization Serv.*, 673 F.2d 1105 (9th Cir.), *rev'd*, ___ U.S. ___, 103 S.Ct. 281, 74 L.Ed.2d 12 (1982) (no affirmative misconduct).

[30] Apellants advance additional arguments in support of reversal. Since the majority does not reach them, I see no necessity for a discussion of them in dissent.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 82-5098

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., A NON-PROFIT CORPORATION, ADA WERNER, AN INDIVIDUAL, FRANK E. WERNER, AN INDIVIDUAL, AND SHIRLEY SORGER, AN INDIVIDUAL, APPELLANTS,

v.

JOSEPH A. CALIFANO, JR., SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, AND THE TRAVELERS INSURANCE COMPANIES, A CORPORATION, APPELLEES.

(D.C. Civil No. 78-74 Erie)

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., A NON-PROFIT CORPORATION, APPELLANT,

v.

PATRICIA ROBERTS HARRIS, SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, AND THE TRAVELERS INSURANCE COMPANIES, A CORPORATION, APPELLEES.

(D.C. Civil No. 80-056B Erie)

SUR PETITION FOR REHEARING

Present: SEITZ, *Chief Judge*, ALDISERT, ADAMS, GIBBONS, HUNTER, WEIS, GARTH, HIGGINBOTHAM, SLOVITER, BECKER, *Circuit Judges*, and MEANOR, *District Judge*.*

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*Honorable H. Curtis Meanor, United States District Court for the District of New Jersey, sitting by designation, was on the original panel but did not participate in this order.

The petition for rehearing filed by Appellees in the above entitled case having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges in regular active service not having voted for rehearing by the court in banc, the petition for rehearing is denied.

Judge Garth would grant the petition for rehearing essentially for the reasons expressed in Judge Meanor's dissenting panel opinion.

By the Court,

/s/ A. Leon Higginbotham, Jr.
Circuit Judge

Dated: FEBRUARY 14, 1983

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 80-56 Erie

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., A NON-PROFIT CORPORATION, PLAINTIFF

v.

PATRICIA ROBERTS HARRIS, SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE TRAVELERS INSURANCE COMPANIES, A CORPORATION, DEFENDANTS.

MEMORANDUM OPINION

On April 10, 1980, Community Health Services (CHS), a nonprofit corporation existing under the laws of Pennsylvania, filed a complaint under § 1878(f)(1) of the Social Security Act (the Act), 42 U.S.C. § 1395oo(f)(1), to review a final decision of the Secretary of the Department of Health and Human Services (the Secretary) disallowing certain claims for Medicare reimbursement for the years 1976 and 1977.[1] This decision was rendered by the Department's Provider Reimbursement Review Board (PRRB) on March 12, 1980 following a formal hearing.

Defendants moved for summary judgment on August 25, 1980 and plaintiff responded with a similar motion on September 17, 1980. The matter was argued orally before the court in Erie on October 30, 1980 and the matter is now ready for disposition.

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[1] On June 3, 1980 this action was consolidated with C.A. No. 78-74 Erie, a case filed on July 12, 1978 based on the same facts. In that case, the court denied motions to dismiss and for summary judgment pending further discovery and agency action. By stipulation of counsel, the Secretary agreed to cease recoupment of the overpayment and refund all monies already recouped from plaintiff pending resolution of this action.

BACKGROUND

Without delving into great detail concerning the statutory scheme for Medicare funds, some explanation of the parties and the plan is necessary. Plaintiff is a "home health agency" as defined in § 1861(o) of the Act, 42 U.S.C. § 1395x(o), and is a "provider" of home health services within the meaning of § 1851(a), 42 U.S.C. § 1395x(u). Defendant Harris is the federal officer responsible for the administration of the Social Security Act. Defendant, Travelers, acted as a fiscal"intermediary" under § 1816, 42 U.S.C. § 1395h and, as such, acted as an agent of the government in making payments to providers of home health services under Parts A and B of Title XVIII of the Act. The primary duty of the intermediary is the processing of claims and payment of funds to the provider.

Beginning in 1966, CHS entered into an agreement with the Secretary to provide home health services to eligible individuals under the Act and the Secretary agreed to reimburse CHS the reasonable cost of such services. Since that time, CHS has been dealing with the Secretary's fiscal intermediary, providing it with all cost related information required. In April of 1975, CHS entered into a series of contracts with the Mercer County Consortium Services, Inc., by which CHS was to employ participants in a program under the Comprehensive Employment and Training Act of 1963 (CETA), 29 U.S.C. § 801 *et seq.* CETA established programs designed to provide job training opportunities for unemployed individuals by allocating funds to state or local governments which, in turn, arrange manpower programs. Under the terms of the CETA grants, CHS was to employ participants in the program furnished by the regional CETA administration and was reimbursed by CETA for the salaries and fringe benefits paid to those employees. The purpose of the CETA program, as stated in the contract signed by CHS, is "to provide work training and experience for the purpose of enhancing the future employability of participants in obtaining a planned occupational goal."

The administrator of CHS contacted a representative of the intermediary to discuss the treatment of the CETA grants for purposes of Medicare reimbursements. While there was no official government policy on the treatment of CETA funds, CHS was informed by the medicare manager of the intermediary, Michael J. Reeves, that the CETA funds qualified as "seed money" pursuant to § 612.2 of the Provider Reimbursement Manual (HIM-15-1) and that the actual cash value of CETA employees need not be offset against reimbursable costs. CHS prepared its cost reports on this basis and these reports were approved by the intermediary for the years 1975, 1976 and 1977. In effect, CHS was being paid twice by the government for the salaries of CETA participants—the Secretary was charged for the salaries of these employees as part of the reasonable cost of providing medical care while CETA was paying for these salaries from government grants. It was not until August 4, 1977 that the intermediary requested a formal opinion from superiors and learned that CETA funds were to be offset against costs. Plaintiff was advised of this by letter dated October 7, 1977 and by personal instructions from Mr. Reeves on November 9, 1977.

Pursuant to the statutory procedure, the Secretary reopened plaintiff's cost reports for 1975, 1976 and 1977 to make adjustments for the CETA funds which should have been offset against costs. Notices of Program Reimbursements were sent to plaintiff. CHS than appealed this determination to the Provider Reimbursement Review Board (PRRB) and was provided with a trial-type hearing on January 22, 1980. The PRRB denied plaintiff's appeal on March 12, 1980 and this appeal followed.

Judicial review of the PRBB decision is limited to that set out in § 10(e) of the Administrative Procedure Act (APA), 5 U.S.C. § 706(2)(E). 42 U.S.C. § 1395oo(f)(1). That section reads, in pertinent part:

> [t]o the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability

> of the terms of an agency action. The review court shall — . . .
>
> (2) hold unlawful and set aside agency action, findings, and conclusions found to be — . . .
>
> (E) unsupported by substantial evidence in a case subject to review on the record of an agency hearing.

In making this determination, the court shall review the whole record, or those parts cited by the parties. Questions of fact are reviewed on the substantial evidence standard while, in deciding questions of law, the court must determine whether the correct legal standard was applied.

I. Did the PRRB Err As A Matter of Law In Holding That CETA Funds Do Not Qualify For The "Seed Money" Exception?

Plaintiff argues that the PRRB erred as a matter of law in concluding that the CETA funds which were used by CHS to pay its CETA employees were not "seed money" and therefore, should have been deducted from operating costs in computing reimbursable costs. We have carefully reviewed the decision of PRRB on this point and conclude that there was no error in excluding CETA funds from the "seed money" exception.

The plain language of the relevant statutes under the Act are clearly supportive of the PRRB's determination. At 42 C.F.R. § 405.423(a), the regulations provide that grants to providers shall, for the purposes of reimbursement, be treated as follows:

> Unrestricted grants, gifts and income from endowments should be deducted from operating costs in computing reimbursable cost. Grants, gifts, and endowment income designated by a donor for paying specific operating costs should be deducted from the particular operating cost or group of costs.

The term "restricted grant" is defined at 42 C.F.R. § 405.423(b)(2) as:

> . . . funds, cash or otherwise, which must be used only for the specific purpose designated by the donor. This does not refer to unrestricted grants, gifts, or income from endowments which have been restricted for a specific purpose by the provider.

The CETA funds at issue in this case cannot be characterized as "unrestricted funds." The agreement under which plaintiff receives the CETA funds specifically states that "Grantor agrees that for the duration of the term of this Agreement, Grantor will (b) Reimburse Grantee for actual costs incurred in Grantee's payment of compensation and fringe benefits to participants provided by Grantor.... (Tr. 424) Certain restricted grants, however, qualify for the "seed money" exception which is found in the Department's Provider Reimbursement Manual, HIM-15, Part I, § 612, entitled "Public Health Service Grants." A Public Health Service Grant is one which is authorized under the Public Health Service Act, 42 U.S.C. § 201 *et seq.* The exception for "seed money" is as follows:

> [G]rants designated for the development of new health care agencies or for expansion of services of established agencies are generally referred to as "seed money" grants. "Seed money" grants are not deducted from costs in computing allowable costs. These grants are usually made to cover specific operating costs or groups of costs for services for a stated period of time.

Our attention is particularly drawn to the words "designated for the development of new health care agencies." Clearly CETA funds were not specifically so designated and no tortured construction of the statute could bring the CETA grants within the "seed money" exception.

Plaintiff argues that the CETA funds were used to employ additional personnel at CHS and therefore resulted in an expansion of health care service at the institution. It contends, therefore, that since the net effect of the utilization of the CETA money was to benefit and expand a health care agency, the CETA funds should qualify under the "seed money" exception. The PRRB adequately addressed this argument and concluded that this is insufficient to bring CETA funds within the exception. (PRRB decision at 5) We therefore find that the PRRB did not err as a matter of law in reaching this determination.

II. Should The Government Be Estopped To Recoup These Overpayments?

Plaintiff argues that the government should be estopped from recovering the overpayment in this case since from

the spring of 1975 through August of 1977 it had been assured by a representative of the intermediary that CETA funds would not be offset for the purposes of Medicare reimbursement. Subsequently, on September 20, 1977, the Medicare Bureau informed the intermediary, who in turn informed CHS, that CETA funds are restricted grants and not within the "seed money" exception. Plaintiff alleges that it relied to its detriment on this advice and spent the money represented by the additional Medicare reimbursement on expanding its services. According to plaintiff, these facts establish detrimental reliance by the provider on misinformation given it by the intermediary.

It is now clearly established that estoppel may lie against the government in certain limited circumstances. *Brown* v. *Richardson*, 395 F. Supp. 185 (W.D. Pa. 1975). These circumstances were discussed thoroughly in *Brown* v. *Richardson* and the court held that the government could not be estopped to deny benefits as the result of a statement made in a Medicare handbook. In reaching this conclusion, the court cited the Supreme Court decision in *Utah Power and Light Co.* v. *United States*, 243 U.S. 389 (1917) which held that:

> [T]he United States is neither bound nor estopped by acts of its officers or agents in entering into an arrangement or agreement to do or cause to be done what the law does not sanction or permit. 395 F. Supp. at 189.

The court went on to note that:

> [B]y operation of law, parties dealing with the government are charged with knowledge of, and are bound by, statute and lawfully promulgated regulations, and reliance upon incorrect information received from government agent or employee cannot alter the terms of a statute regardless of the economic hardship which may result. *Id.* at 190.

In this case, the regulations dealing with Medicare reimbursement clearly provide that only those grants "designated" for the expansion of health care services would qualify under the "seed money" exception. The fact that Mr. Reeves erroneously advised CHS that CETA funds qualified

for the exception cannot alter the principles upon which the Medicare Act is based. Even if estoppel would properly lie in this case, the plaintiff's unjustified reliance upon the advice of the intermediary would preclude application of the doctrine. As stated in *Brown* v. *Richardson*, "an estoppel arises where one party by words or action makes a false representation of fact and the other party reasonably relies on that representation and is prejudiced thereby." *Id.* at 191. Elaborating on the reasonableness of reliance, the court stated:

> One who claims the benefits of an estoppel on the ground that he has been misled by the misrepresentations of another must not have been misled by his own lack of reasonable care and circumspection. A lack of diligence by a party claiming an estoppel is generally fatal. If the party conducts himself with careless indifference to the means of information reasonably at hand or ignores highly suspicious circumstance, he may not invoke the doctrine of estoppel.

The Medicare regulations allow the intermediary to reopen the cost reports up to three years after they have been approved. Thus, CHS relied at its own risk in accepting the intermediary's advice since plaintiff was on notice that all such reports were subject to review. Moreover, the fact that CHS was being reimbursed twice for the same expense should have been a red flag that its windfall was not supportable under the Act.

III. Is Defendants Attempt to Recoup The Overpayments Contrary to Law?

Plaintiff argues that if indeed it did receive an overpayment due to the treatment accorded to the CETA grants, defendants acted contrary to law by attempting to recoup those overpayments since it was without fault. This argument is premised on 42 U.S.C. § 1395gg and 42 C.F.R. § 405.355 which provide for waiver of adjustments in certain circumstances. Congress provided in the Act at 42 U.S.C. § 1395gg(b) and (c):

> (b) Where—
>
> (1) more than the correct amount is paid under this subchapter to a provider of services or other person

> for items or services furnished an individual and the Secretary determines...
>
> (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount...
>
> proper adjustments shall be made ... by decreasing subsequent payments—...
>
> (c) There shall be no adjustments as provided in subsection (b) of this section (nor shall there be recovery) in any case where the incorrect payment has been made ... with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if such adjustment (or recovery) would defeat the purposes of title II or title XVIII or would be against equity and good conscience....

Defendants contend that this section of the Act does not apply in a case such as this, that there is no provision in the Act giving the Secretary authority to waive overpayments to the provider and therefore under 42 U.S.C. § 1395g the Secretary is obligated to recover the overpayments.

Based upon a fair reading of these statutory provisions and the detailed consideration given to them in *Mt. Sinai Hospital of Greater Miami, Inc.* v. *Weinberger*, 517 F.2d 329 (5th Cir.1975) *cert. denied*, 425 U.S. 935 (1976) (hereinafter *Mt. Sinai*), we are unwilling to determine that the Secretary acted contrary to law by seeking to recover the overpayments in this situation.

Section 1395gg deals with preconditions to recovery against individual beneficiaries and provides that in cases of overpayment in noncovered or excluded services where the recoupment could not be recovered from the provider or where the provider was without fault, the Department will not seek recovery from the provider but will determine whether recovery from the beneficiaries is permissible. This implied waiver only exists where, in the absence of recovery from the provider, the overpayment could, if not prohibited by other statutory provisions, be recouped from the beneficiary. This section authorizes the Secretary to recoup overpayments from beneficiary's old-age benefits, but

only where "the excess over the correct amount could not be recouped from the provider. *Mt. Sinai*, 517 F.2d at 336.

In *Mt. Sinai*, the provider contested the Secretary's attempt to recoup payment for medical services and supplies to beneficiaries which later turned out to be medically unnecessary. After an in-depth statutory analysis, the Fifth Circuit Court of Appeals distinguished overpayment arising from noncovered or excluded services from those arising from erroneous "reasonable cost" determinations and held that § 1395gg applied only to overpayments arising from noncovered or excluded services. *Id.* at 340-342. *Mt. Sinai* does suggest in a footnote that in cases of overpayment based on noncovered or excluded services, the lack of fault on the part of the provider would be a defense to recoupment, but does not deal with reasonable costs. *Id.* at 33.

While there is no explicit authority in the statute to waive recoupment from the provider, we find it difficult to believe that the Secretary is wholly without power to do so where it appears that individual recipients would suffer or the purpose of the Act would be frustrated. In addition, we note that in the PRRB Hearing Manual at § 52(g), the Board is denied jurisdiction over "the waiver of an overpayment to a provider or the manner of repayment." The clear implication of this section is that such waivers are permitted should the Secretary determine it appropriate. However the decision of the Secretary not to waive recovery in this case is a discretionary one, presumably based upon all the relevant facts and we are not able to find that his discretion was abused in this case.

IV. Is Plaintiff Entitled To A Pre-Recoupment Hearing?

Plaintiff argues that the denial of its waiver request without an agency hearing constitutes a violation of its right to due process under the Fifth Amendment of the United States Constitution. The PRRB did not address the waiver issue since it is without jurisdiction to do so under § 1150.52(g) of the PRRB Hearing Manual.

As we have just discussed, there is no specific statutory provision requiring waiver by the government in favor of the provider where there have been overpayments as to the

reasonable costs of services. Plaintiff does not base its assertion on any statutory right to waiver, but rather relies on a traditional due process argument that its statutory entitlement to reimbursement for the reasonable cost of services rendered to Medicare beneficiaries creates a property interest which is entitled to procedural due process protection before termination.

In the prior law suit before this court concerning the same overpayments, the Secretary agreed to cease recoupment of the overpayment and refund to plaintiff all monies already recouped. Recoupment was stayed pending resolution of the dispute, and consequently, no portion of the overpayment has been recovered by the Medicare program. In the interim, an indepth hearing was held before the PRRB to determine whether the CETA funds qualified as "seed money" and that the adjustments made were proper. Presently, this court is entertaining plaintiff's arguments on the merits of that decision and the constitutionality of the hearing. Now the plaintiff asks us to find that a pre-recoupment hearing on the question of waiver is constitutionally required. We have already considered the decision of the Secretary not to waive recoupment and have decided that she did not abuse her discretion in reaching this decision. All of this has been afforded plaintiff before any monies have actually been recouped. We therefore find no case or controversy which would enable us to reach the more general question of whether a pre-recoupment hearing on the issue of waiver should be required in all cases.

V. Is Traveler's Independently Liable to Plaintiff?

Plaintiff asserts that Travelers was acting ultra vires by deliberately and consciously misadvising CHS on the cost accounting treatment of CETA funds when it knew that no government policy had been set forth and knew that its advice could not substitute for that of the Secretary. Therefore, plaintiff believes that Travelers should be held independently liable to it for the overpayment.

It is well established that a mere mistake of judgment does not constitute activity outside a federal official's authority so as to make him or her personally liable for dam-

ages. *Butz* v. *Economu*, 438 U.S. 478 (1978). As an agent of the Secretary pursuant to § 1816 of the Act, 42 U.S.C. § 1395h, Travelers and its representatives enjoy the same immunity from damage suits as a federal official. *Matrana* v. *Travelers Insurance Company*, 563 F.2d 677 (5th Cir.1977).

The duties of the intermediary are outlined in the Act at 42 U.S.C. § 1395h(a) and in the agreement entered into between Travelers and CHS. Included among these duties are the responsibility for provide consultative services to the institutions, to serve as a channel of communication to the Secretary and to review and settle provider cost reports. Mistakes in the treatment of cost items were expected and provided for in the regulations. 42 U.S.C. § 405.1885(b) provides:

> (b). A determination or a hearing decision rendered by the intermediary shall be reopened and revised by the intermediary if, within the aforementioned 3-year period, the Health Care Financing Administration notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the intermediary.

In this case there is no question but that Michael Reeves gave incorrect advice to the provider and approved cost reports reflecting that erroneous advice. But there is no evidence of willful or wanton misconduct on the part of Mr. Reeves. It is inconceivable that the government could have an established policy for each and every possible grant received by a provider and it is expected that the intermediary will give its opinion on unexpected questions that arise. It is also expected that those opinions will not always coincide with the position of the Secretary. The regulations make it clear that it is the statutes themselves and the opinion of the Secretary which is controlling. It does appear that Mr. Reeves exercised poor judgment by waiting so long before checking with his superiors on the correct application of CETA funds. However, as earlier stated, mistakes of judgment do not constitute activity outside the fed-

eral official's authority. We find no basis for holding Travelers independently liable to plaintiffs.

VI. Did Defendant's Retroactively Apply a Policy Change Without Complying with the APA?

Plaintiff interpretes [sic] the Secretary's instructions to offset CETA grants against the reasonable costs reimbursed by Medicare as a change in policy requiring the procedure set out in the APA for rulemaking. Further, plaintiff argues that such a change in policy cannot be applied retroactively.

As has been stated earlier, the intermediary's oral advice that the provider's CETA grants constituted "seed money" cannot alter the controlling statutory law. The intermediary was mistaken in its interpretation of the law and its correction of this mistake after seeking and receiving guidance from the Secretary did not constitute a substantive change in the Secretary's policy. Since we have determined that there never was an official "policy" with respect to the treatment of CETA funds, there cannot have been a policy change.

VII. Did PRRB Improperly Exclude Evidence Offered By Plaintiff?

Plaintiff alleges that the PRRB abused its discretion by preventing it from introducing evidence showing discriminatory application of governmental policy by denying its request to subpoena or depose a particular witness and by precluding it from showing Travelers' arbitrary application of the policy with respect to CETA grants.

Under 5 U.S.C. § 556(c), employees presiding at agency hearings are to issue subpoenas authorized by law, rule on offers of proof and receive relevant evidence, have depositions taken when the ends of justice would be served, and regulate the course of the hearing. Further in 5 U.S.C. § 556(d), the agency is authorized to provide for the exclusion of irrelevant, immaterial or unduly repetitious evidence. The record indicates that after an offer of proof and extensive argument, the chairman of the PRRB ruled that the testimony of the witness who refused to appear voluntarily, was not "germane to the basic question in this case

as to whether or not this Provider was treated in accordance with the regulations and fairly and given due process and so it will not be accepted." (Tr., 160).

The hearing examiner has wide latitude as to all phases of conduct of the administrative hearing. *Cella* v. *United States*, 208 F.2d 783 (7th Cir. 1953), *cert. denied*, 347 U.S. 1016, and the definition of the scope of the proceeding raises questions which particularly call for agency judgment. *Ashbacker Radio Corp.* v. *Federal Communications Commission*, 326 U.S. 327 (1945). We have reviewed the colloquy leading up to the evidentiary ruling and studied the issues before the Board, and cannot see that the exclusion of this evidence was in any way an abuse of the PRRB's discretion.

For all the above reasons, we find the merits of this undisputed controversy to lie with the defendants and therefore grant their motion for summary judgment. Of necessity, plaintiff's motion must be denied. An appropriate order will be entered.

/s/ William W. Knox

U.S. District Judge

DECEMBER 29, 1980

cc: Counsel of record.

APPENDIX D

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

80-D12

Case No. 78-215

PROVIDER—COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC. MEADVILLE, PENNSYLVANIA
PROVIDER NO. 39-7041

v.

INTERMEDIARY—THE TRAVELERS INSURANCE COMPANY

Date of Hearing—January 22, 1980
Cost Reporting Period Ending—October 31, 1975, 1976 and 1977

ISSUE

Whether or not Comprehensive Employment and Training Act Funds (CETA) qualify as unrestricted funds pursuant to 42 CFR 405.423?

SUMMARY OF FACTS

Community Health Services of Crawford County, Inc., is a nonprofit home health agency. The agency performed 5,210, 7,757, and 8,246 home health visits for the cost reporting periods respectively ending October 31, 1975, 1976 and 1977. Cost reports for the aforementioned periods were filed with the Provider's fiscal intermediary, Travelers Insurance Company.

During the periods in question, the Provider included in its reimbursable cost the salaries and fringe benefits of CETA employees. Pursuant to the CETA participatory agreements, the Provider was reimbursed for the salary and fringe benefits of its CETA employees. Accordingly, the Provider received the following reimbursement for its CETA employees:

1975	$16,555
1975	$53,952
1977	$81,118

In filing its cost reports for the periods ending 1975 and 1976, the Provider included in allowable costs the salary and fringe benefits of CETA employees without a corresponding offset for the CETA funds received. The Intermediary accepted the Provider's treatment of the CETA funds received. Notices of Program Reimbursement were issued the Provider on April 19, 1976 and April 12, 1977, for the cost reporting periods respectively ending October 31, 1975 and 1976. Throughout these periods, it was the opinion of the Intermediary that CETA funds qualified as "seed money" pursuant to Section 612.2 of the Provider Reimbursement Manual (HIM-15-1). On August 4, 1977, the Intermediary sought advice from the Philadelphia Regional Office of the Health Care Financing Administration (HCFA) concerning the treatment of CETA funds. In response to this inquiry, the Regional Office advised Travelers on September 20, 1977, of the following:

> "Where the employer includes these persons on its payroll, the amounts reimbursed by CETA for wages and fringes should be offset against the cost." (Intermediary's Position Paper, Exhibit 5)

Travelers, therefore, notified the Provider on October 7, 1977, that where CETA participant's wages and fringes are included in the expenses of a provider, applicable CETA grants must be used to offset expenses for Medicare cost reimbursement purposes. Subsequently, the Provider filed its cost report for the period ending October 31, 1977, on February 2, 1978. Once again, the Provider did not give recognition to offsetting salaries and fringe benefits by CETA Funds. Hence acting on the advice of HCFA's Regional Office, Travelers revised the Provider's 1975 and 1976 settlements to recognize such an offset. Revised Notices of Program Reimbursement were mailed to the Provider on May 24, 1978 and June 5, 1978, for the cost years respectively ending October 31, 1975 and 1976. Likewise, as a result of a desk review of the Provider's 1977 cost report, a similar offset was made for CETA funds. A Notice of Program Reimbursement for 1977 was mailed to the Provider on June 26, 1978. The Provider takes exceptions to

these adjustments and has filed a timely appeal before the Provider Reimbursement Review Board.

The Provider submits that the offsetting of CETA funds against salaries and fringe benefits is improper. The Provider contends that CETA funds qualify as "seed money" pursuant to Section 612.2, HIM-15-1. In the instant case, the Provider alleges that the receipt of CETA funds enabled it to expand its scope of services.

> "*Seed-Money Grants.*—Grants designated for the development of new health care agencies or for the expansion of services of established agencies are generally referred to as 'seed money' grants. 'Seed money' grants are not deducted from costs in computing allowable costs." (Section 612.2, HIM-15-1)

The CETA funds, argues the Provider, are to supplement its funds not supplant its funds.

> "CETA funds will, to the extent practicable, be used to supplement, rather than supplant the level of funds that would otherwise be available for the planning and administration of programs under the eligible applicant's grants [Section 703(ii)]." (Assurances and Certification attachment to Memorandum of Agreement, Provider's Position Paper, Exhibit J)

The Assurances and Certifications of the CETA Grant further provide:

> "Jobs are in addition to those that would be funded by the sponsor in the absence of assistance under the Act Section 205(c)(24)."

Accordingly, the Provider asserts that CETA grants should be accorded the treatment of "seed money."

Further, the Provider argues that the Intermediary is estopped from raising the issue of offset. The estoppal argument is predicated on the fact that the Intermediary for nearly two years advised the Provider that salaries and fringe benefits need not be offset by CETA funds.

To the contrary, the Intermediary asserts that CETA funds do not qualify as "seed money." The Congressional intent of CETA funding is to provide jobs or training for the unemployed. Congress did not view CETA funding as a mechanism to expand health care services. Further, the In-

termediary argues that pursuant to 42 CFR 405.1885(b), it is required to revise a provider's settlement where an earlier determination is contrary to applicable general instructions. Hence the Intermediary is not estopped from revising prior cost settlements.

CITATION OF APPLICABLE LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

A. Regulations—42 CFR 405, Regulations No. 5, Subpart D

Section 405.423 Grants, gifts, and income from endowments

B. Program Instructions—Provider Reimbursement Manual, Part 1 (HIM-15-1)

Section 612.2 Seed-Money Grants

CONCLUSIONS AND FINDINGS

The Provider Reimbursement Review Board, after consideration of the facts, the parties' contentions, and evidence presented concludes and finds that salaries and fringe benefits paid to CETA employees must be offset by the receipt of CETA funds for the period ending October 31, 1977.

The Regulations at 42 CFR 405.423 very implicitly state that donor-restricted funds which are designated for paying certain hospital operating expenses should apply and serve to reduce these costs or group of costs. In the instant case, the CETA grant was restricted to specifically pay the salaries and fringe benefits of the CETA employees of the Provider.

> "5. Grantor agrees that for the duration of the term of this Agreement, Grantor will:
>
> . . .
>
> b) Reimburse Grantee for actual costs incurred in Grantee's payment of compensation and fringe benefits to participants provided by Grantor . . ."
>
> (Memorandum of Agreement, Intermediary Position Paper, Exhibit 1)

Further, the Board finds the purpose of "seed money" as defined by Section 612.2, HIM-15-1 and a CETA grant is

clearly distinguishable. "Seed money" as defined by the Manual is a grant designated for the development of new health care agencies or for the expansion of services of established agencies. The purpose of the Comprehensive Employment and Training Act of 1973 is "to provide job training and employment opportunities for economically disadvantaged, unemployed, and under employed persons, and to assure that training and other services lead to maximum employment opportunities." (29 USC 801—Congressional statement of purposes) Although the residual effect of CETA funding in the instant case may have contributed toward an expansion of services, the purpose of CETA funding is clearly to assure opportunities for employment and training to unemployed and under employed persons. (House Report No. 93-659) The Board finds that greater weight must be accorded the purpose of a donor restricted grant rather than an alleged residual effect in determining whether a grant qualifies as "seed money."

Further, the Board finds that the adjustments proposed to the 1975 and 1976 cost reports are improper. Pursuant to 42 CFR 405.1885, a determination of an intermediary may be reopened within three years of the date of a Notice of Program Reimbursement. The Regulations continue to state:

> "Section 405.1887 Notice of Reopening
>
> (a) All parties to any reopening described above shall be given written notice of the reopening. When such reopening results in any revision in the prior decision, notice of said revision or revisions will be mailed to the parties with a complete explanation of the basis for the revision or revisions . . ."

These principles are also reiterated in Part A Intermediary Manual, Part 2, Audits Reimbursement Program Administration (HIM-13-2). Section 2632, HIM-13-2, directs the intermediary to give written notice to the provider of a reopening. In reviewing the record for the cost reporting periods ending October 31, 1975 and 1976, no such notice was given the Provider. In addition, the Board finds that the Intermediary is barred by statute from giving notice of a reopening for the 1975 cost reporting period. However, the defect for the 1976 cost reporting period may be corrected. The statute of limitation for the latter year extends

to April 14, 1980. Should the Intermediary render a timely notice of reopening to the Provider for the cost reporting period ending October 31, 1976, the decision of this Board for the cost reporting period ending October 31, 1977, will be equally applicable to the 1976 cost reporting period.

Finally, the Board would like to acknowledge the Provider's argument concerning the role of the fiscal intermediary. The Regulations succinctly state that "an important role of the fiscal intermediary, in addition to claims processing and payment and other assigned responsibilities, is to furnish consultative services to providers in the development of accounting and cost-finding procedures which will assure equitable payment under the program" [42 CFR 405.401(e)]. However, it should be emphasized that the role of the intermediary is not to establish the principles of reimbursement. This is the responsibility of the Secretary. Although the Provider acted in good faith in not offsetting salaries and fringe benefits by CETA funds, advice by the Intermediary cannot be a substitute for the opinion of the Secretary.

DECISION

The Intermediary is sustained for the cost reporting period ending October 31, 1977. CETA funds are not to be treated as "seed money." The adjustments of the Intermediary are reversed for the periods ending October 31, 1975 and October 31, 1976, inasmuch as proper notices of reopening were not sent to the Provider.

In the event that the Intermediary renders a timely notice of reopening to the Provider for the cost reporting period ending October 31, 1976, the decision of this Board for the cost reporting period ending October 31, 1977, will be equally applicable to the 1976 cost reporting period.

Board Members Participating

Thomas M. Tierney
Carolyn B. Lewis
H. Joseph Curl

FOR THE BOARD

/s/ Thomas M. Tierney

THOMAS M. TIERNEY
Chairman

March 12, 1980

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 82-5098

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., a non-profit corporation, ADA WERNER, an individual, FRANK E. WERNER, an individual, and SHIRLEY SORGER, an individual

v.

JOSEPH A. CALIFANO, JR., SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, AND THE TRAVELERS INSURANCE COMPANIES, a corporation

(D.C. Civil No. 78-74 Erie)

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., a non-profit corporation

v.

PATRICIA ROBERTS HARRIS, SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, AND THE TRAVELERS INSURANCE COMPANIES, a corporation

(D.C. Civil No. 80-056B Erie)

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., ET AL., APPELLANTS

(D.C. Civil Nos. 78-0074 & 80-056B Erie)

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA—ERIE

Present: Aldisert, Higginbotham, *Circuit Judges;* Meanor, *District Judge* *

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*Honorable H. Curtis Meanor, United States District Court for the District of New Jersey, sitting by designation.

JUDGMENT

This cause came on to heard on the record from the United States District Court for the Western District of Pennsylvania—Erie and was argued by counsel September 29, 1982.

On consideration whereof, it is now here ordered and adjudged by this Court that the order of the said District Court entered November 16, 1981, be, and the same is hereby reversed and the cause remanded to the said District Court which is directed to grant appellants' petition to estop the Secretary from recouping the alleged overpayment. Costs taxed against appellee.

ATTEST:
/s/ Sally Mrvos
Clerk

JANUARY 19, 1983

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1983

No. 83-56

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

MOTION TO DISPENSE WITH THE REQUIREMENT OF A JOINT APPENDIX

Pursuant to Rule 30.7 of the Rules of this Court, the Solicitor General, on behalf of the Secretary of Health and Human Services, seeks leave to dispense with the requirement of a joint appendix in this case.

The question presented by this case is whether the Secretary of Health and Human Services may be estopped from recovering excess payments made to a provider of health care services under the Medicare program on the ground that a fiscal intermediary previously had advised the provider that the payments were allowable. The facts in the case, which are largely undisputed, are set out in considerable detail in the opinions of the Provider Reimbursement Review Board, the district court, and the court of appeals. These opinions are printed in the appendix to the petition for a writ of certiorari. In these circumstances, there is no justification for printing of a joint appendix.

Counsel for respondents have authorized me to state that they join in this request.

Respectfully submitted.

REX E. LEE
Solicitor General

OCTOBER 1983

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